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ABSTRACT

This report offers strategies to prevent unintended pregnancy in an era when the nation's welfare program has a changed mission, more money, and greater reach. The report discusses types of links between welfare offices and family planning services being developed in California, Georgia, and Washington, identifying barriers and challenges to developing links and noting possible solutions. Part 1 defines the link, providing a lexicon for the different ways that welfare agencies might interact with other agencies working on unintended pregnancy. It also summarizes links that have already been established in the three states. It concludes by discussing why states should consider linking welfare and family planning, noting challenges in making the links work and looking at key design questions to consider when formulating new or expanded programs. Part 2 offers the full story of the three states' initiatives, focusing on the history and development of the initiatives, elements of the initiatives, and local implementation. California has a large variety of links at different levels of government and among different agencies. Georgia spends welfare funds on an adolescent pregnancy prevention initiative. Washington has implemented a unified vision of co-location and improved access to voluntary pregnancy prevention services. (SM)

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Making the Link

Pregnancy Prevention and the New Welfare Era

Phyllida Burlingame
Rutledge Hutson
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December 1999

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Phyllida Burlingame is the principal author of this report; she also conducted the California and Washington site visits. Rutledge Hutson conducted the site visit in Georgia. All three authors worked together to develop the conceptual framework of the paper and assisted with the editorial process.

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ABOUT THIS PUBLICATION

Making the Link: Pregnancy Prevention in the New Welfare Era offers strategies to prevent unintended pregnancy in an era in which the nation's welfare program has a changed mission, more money, and greater reach. The enactment of the 1996 welfare law allows federal welfare funds to be spent on an array of pregnancy prevention activities and family planning services; furthermore, welfare funds are no longer limited to welfare recipients who receive grants—funds may be spent on individuals who have never been a part of the welfare system. These fundamental policy changes, along with nearly $8 billion[1] of unspent welfare funds, allow states to consider whether and how to invest in a range of strategies to prevent unintended pregnancy. The law permits, but does not require, any such investment. Nevertheless, a number of states are creating new ways to address unintended pregnancy. Some states are linking welfare offices and family planning services—through co-location, information dissemination, referrals, case management, education, and training. Others are tapping welfare funds to provide education, information, or services to those who might never enter a welfare office. Some programs target adults, others teens; some include a focus on males. **Making the Link** seeks to provide insight into different types of links and how to make them work.

Making the Link profiles three states—California, Georgia, and Washington. Through the experiences of these states, barriers and challenges to developing links are identified, along with possible solutions. These states were selected because their links underscore the breadth of potential approaches to integrating pregnancy prevention and welfare in this new era. California, Georgia, and Washington were also chosen because their linkages appear more established than those now emerging in other states. Indeed, while the redesign of federal welfare law in 1996 may propel states to establish or expand links, some of the initiatives described in this publication began or built upon actions taken before the 1996 welfare redesign.

Not examined in **Making the Link** are policies that condition welfare eligibility on reproductive behavior. For example, around 20 states have implemented a "family cap" or "child exclusion" policy which denies cash aid to an infant born to a welfare recipient; under this policy, a family's grant is capped and does not increase to reflect the additional child. In about 10 states, an individual responsibility agreement (IRA) can condition receipt of welfare on some type of reproductive health requirement such as a visit to a family planning provider. These interfaces are important but have been reviewed in other CLASP publications[2] [see: Appendix A] . One of the challenges in linking family planning and welfare is ensuring against coercion, particularly among those who receive cash grants.[3] Even the perception of coercion could have negative health consequences if people view the offer of reproductive health services with suspicion and mistrust and, for that reason, refuse services.

In some respects **Making the Link** is delivered prematurely. California and Georgia are currently evaluating their linkage efforts (Washington just issued a report). It is significant that each of these three states is determined to learn more about the implementation and/or effects of its initiatives; these findings should prove useful. At the same time, other states may not want to

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wait until the research is concluded to consider how these links could be adopted or adapted in their own states. The field is largely uncharted; it is likely that states and localities will design an array of new models in the years ahead. For example, in the profiled states there are instances where other social service programs, such as WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), incorporate prevention of unintended pregnancy as a program service. Job training programs, employment service offices, housing agencies, and other social service programs could also embrace the need for voluntary pregnancy prevention services. In some communities these other social service agencies may be more appropriate vehicles to foster access to pregnancy prevention services than the local or state welfare agency. CLASP expects to track these developments as well. Commitment to evaluation of all such efforts will help this emerging field become more effective.

Little national survey research has been done to ascertain which states are making links and what their linkages entail; thus, it is possible other states besides California, Georgia, and Washington have links that are as established and extensive.[4] One preliminary review, however, found that there are significant barriers to "creating welfare programs that explicitly stress pregnancy prevention."[5] This preliminary finding likely still holds true. At the same time, it increasingly appears that states and localities, while not necessarily creating specific welfare programs that stress pregnancy prevention, are now beginning to accomplish important interactions between welfare and pregnancy prevention agencies. For example, in the last few years, family planning agencies in states such as Alaska, Kentucky, Montana, and Utah have begun training welfare staff about how to raise the topic and how to make appropriate family planning referrals.[6] While effective training and skilled referral may appear a modest task, its accomplishment requires overcoming any political barriers as well as inherent differences between the "cultures" of the welfare and family planning agencies. In some places, cooperative health and welfare ventures may be more appropriate and more effective than pregnancy prevention programs designed and implemented solely by the welfare agency. To get a better understanding of links emerging around the country and the scope of the "culture" issue, CLASP has embarked on a partnership with the State Family Planning Administrators (SFPA). Forthcoming analysis should assist in developing a national perspective.

In **Making the Link** some terms are used in a "shorthand" manner to convey broader meaning. The term "link" is intended to apply to the variety of ways that welfare funds or the welfare system might connect with pregnancy prevention and family planning services to promote their voluntary utilization by low income individuals—those inside and those outside of the welfare system. The term "family planning" is sometimes used as shorthand for both clinical family planning services and the variety of activities that can contribute to the prevention of unintended pregnancy. It applies equally to a first or subsequent pregnancy.[7] The term "welfare" means welfare in the new era, with its increased flexibility to reach both cash aid recipients and non-recipients and to provide clinical family planning services and other pregnancy prevention services (e.g., education, case management, youth development). Finally, "welfare system" is used to refer to the system of cash aid.

Making the Link has two parts. Part One defines the links—it provides a lexicon for the different ways the welfare agency might interact with other agencies working on unintended pregnancy. It then offers a brief summary of the links that already have been established in the

three states. Part One concludes with a section on implementation—the challenges inherent in making the links work and the key design questions to consider in formulating new or expanded programs. This is our best effort to cull the lessons emerging from the profiled states. Part Two offers the full story of the three states' initiatives. In California, the sheer variety of links occurring at different levels of government and among different agencies makes the state a rich resource for ideas on possible links and implementation issues. Georgia's story is about the decision to spend welfare funds on an adolescent pregnancy prevention initiative—one of the first in the nation to do so. The push and pull of the politics behind tapping welfare funds for this purpose is described along with illustrations of how the money has been invested in several localities. In Washington, the state developed and implemented a unified vision of co-location and improved access to voluntary pregnancy prevention services. This story describes the origins and refinement of this cutting-edge vision.

Our research shows that links are feasible, they are happening in some places, and, at least anecdotally, they are helping to provide needed services that might not otherwise be available. **Making the Link** provides, we hope, a tool for those interested in forging family planning and welfare links.

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INTRODUCTION

"Twenty years ago, we wouldn't have thought of having a family planning nurse in our welfare office. It wasn't in the paradigm."

Candy Peterson
Social Services Supervisor
Bellingham Community Service Office
Washington, 1999

The family planning and welfare paradigm is shifting. Once disengaged from each other, the two systems appear increasingly to come together in state and local initiatives around the country.

Congress first tried to link welfare with family planning in 1967. At that time, Congress required states to make voluntary family planning services available to a welfare recipient upon request.[8] Whether, and to what extent, states translated this little-known provision of the Aid to Families with Dependent Children (AFDC) program from paper to practice is not evident.[9] Even though the provision was mandatory, each state determined how to fulfill the requirement and could do so by making brochures available in a waiting room. Proponents of the provision may well have expected more. These modest connections could be, as one recent study suggests, the function of an historical disconnect, in which "[t]he health agencies that traditionally administered pregnancy prevention programs have usually not worked closely with welfare agencies. . . ."[10]

The 1996 welfare law[11] eliminated the little-known AFDC family planning provision. The new law, instead, includes a number of incentives and flexible funding for states to take steps that address family planning, pregnancy prevention, and out-of-wedlock births. As one American Public Human Services Association official recently observed: "The goals set forth in the 1996 welfare reform law place a special emphasis on pregnancy prevention for the first time. States have responded by leveraging the new, flexible welfare funds with existing investments to expand and create new and innovative programs."[12]

The incentives are included in the Temporary Assistance to Needy Families (TANF) block grant that replaced AFDC and also in a new abstinence-unless-married education program.[13] For example, while the 1967 provision was eliminated, TANF explicitly allows states to spend federal TANF funds on family planning services;[14] in contrast, TANF may not pay for any other medical services. Significantly, these funds may be spent on those who have never received cash aid and may be used to provide family planning services to men and women in a wide range of age and income groups. Thus, the new law provokes consideration of broad approaches that may not be limited to the traditional welfare population. Other relevant provisions of the 1996 law include:[15]

- Purpose statement. States may spend TANF funds for four purposes; one of these is to "prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies."

- "Bonus to reward a decrease in illegitimacy." $100 million is available each year for up to five states with the greatest reduction in non-marital births, as well as a reduction in abortions.[16]

- Abstinence education. $50 million is available each year for five years for states to teach abstinence education, defined in part as education that "has, as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity." A state match of $3 dollars for every $4 of federal funding is required.

Initiatives that enhance access to and voluntary use of reproductive health and pregnancy prevention services are needed. The federal funding sources for family planning services, Medicaid, CHIP, Title X, Title V, and Title XX,[17] are simply not meeting the demand for publicly funded family planning. Only 39% of women in need of publicly supported contraceptive services obtain them.[18]

More than three million pregnancies each year, nearly half of all pregnancies in the United States, are unintended. Younger women, those never-married, and poorer women are more likely to have an unintended pregnancy,[19] but no one is immune. For example, about one-third of the pregnancies to women in their early 30s are unintended, as are those of married women. And, while unintended pregnancy is higher for women living below poverty, more than four out of every ten pregnancies to women over 200% of poverty are also unintended.[20]

Nearly half of the couples with an unintended pregnancy were not using birth control.[21] What accounts for this inability to plan for the birth of a child? As noted by the Alan Guttmacher Institute:

> "The reasons . . . often relate, in one way or another, to lack of access. Some people may not be able to afford birth control methods on an ongoing basis; 15% of women of childbearing age (15-44) live in poverty, and one in six have no Medicaid or private insurance coverage. Some people may live far from the contraceptive services required to use medical methods.
>
> Others may be embarrassed to buy contraceptives or seek services, be reluctant to admit that they are having sex or be afraid of parental or community disapproval. Only 40% of young women go to a doctor or clinic for contraceptive services within the first year after they begin."[22]

An unplanned pregnancy can make it particularly difficult to get, keep or advance in a job. Despite various legal protections, some employers may be reluctant to hire a woman who is pregnant. Workers with young children may also struggle with unavailable or unreliable child care. Employers may be unwilling to retain workers if child care problems cause "too many"

absences. Such problems may force these workers, particularly young mothers, to bounce from one job to another.[23]

Welfare recipients and other low income women with young children are increasingly in the workforce. Within the low income population, the recent employment increase is most dramatic among single women. Today, the majority of single mothers under 200% of poverty with children under age six are employed.[24] Although more low income women are working, there is evidence to suggest that these women face substantial obstacles to retaining or advancing in their jobs. For example, one state study of former welfare recipients asked about the ways in which child care difficulties affect employment. More than half of the women surveyed reported that child care problems created barriers to job retention or advancement.[25]

Within the welfare system, states are mandating that mothers engage in work activities when their children are newborns. In about half the states, a mother with a child six months of age or younger can be denied some or all of a cash grant if she does not participate in a work activity—in nine of those states she can be required to participate the day of birth.[26] In addition, federal law limits a family to 60 months of federal assistance. In light of these provisions, a family's decision about when to have children becomes even more important and access to family planning services even more critical. A planned pregnancy allows the family to individually determine how to maximize needed supports—from within and outside the family.

To enhance employment opportunities, promote job stability and "bank" welfare receipt for unforeseen future problems, low income women and men need a vital support service—family planning—that is designed to avoid unintended pregnancy. Families need this support service along with those more traditionally associated with employment (e.g. child care and transportation). However, the provision of such service in this context represents a new way of addressing unintended pregnancy. The family planning and welfare paradigm is shifting. So that others may consider whether and how to make this paradigm shift in their own community, **Making the Link** offers some lessons from California, Georgia, and Washington where this new of way of thinking has taken root.

PART ONE

Making the Link: Implementation Issues

WHAT ARE WELFARE AND FAMILY PLANNING LINKAGES?

Various types of linkages may be made between welfare and family planning or pregnancy prevention agencies. The definitions that follow are offered to provide a common vocabulary. The mechanisms for linking welfare with pregnancy prevention seem fairly straightforward. What makes the linkages interesting and unique is the choices a state or locality makes when implementing one or more of these potential of linkages. Subsequent to the definitions below, the choices made by California, Georgia, and Washington are briefly described. Then, the lessons from these states' experiences are synthesized.

Definitions

- **Co-location.**

When welfare and family planning services are offered at the same site, they are "co-located." Co-location translates into a variety of arrangements depending on space, resources, and the degree of cooperation between agencies. For example, a family planning clinic could rent space in the same building as the welfare office but not be otherwise connected. Or a family planning clinic could adjoin the waiting room of the welfare office, so that welfare clients could utilize its services while waiting to see their caseworkers. Alternatively, a family planning provider could be based in the welfare office to provide services such as education, counseling, and certain types of birth control.

- **Information dissemination.**

There are numerous ways that family planning and welfare agencies can disseminate information to welfare clients. Among these are: an informational brochure on family planning distributed in clients' intake packets, a poster hung in a waiting room, a toll-free number listed on an application, and a transit advertising campaign.

- **Referrals.**

Referrals are a vital link in the chain between providing information and providing service to a client. Welfare caseworkers might be prepared to hand clients written family planning information or to ask if they are interested in receiving information or services, but these staff members do not have the training to provide the next step themselves. They therefore refer interested clients to a family planning clinic or an on-site family planning specialist. By utilizing referrals in this way, states or agencies can take advantage of the existing contact between the welfare worker and the client in order to engage in outreach.

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- **Case management.**

Case management programs establish one-on-one relationships in which case managers coordinate the services clients need, including education, child care, and health care. A number of states have established case management programs for teens receiving welfare. As well as referring clients for family planning services, case managers can discuss the topic with them on an ongoing basis.

- **Client Education.**

Educating clients about reproductive health is an important component of all family planning programs. Providers believe clients need to learn about general reproductive health matters and about the various methods for preventing pregnancy and sexually transmitted diseases before they can make informed decisions about their health care. Family planning education for welfare recipients can be provided at welfare offices to individuals or through group classes. Family planning educators can also do outreach and education at other sites where there is a high density of welfare recipients and other low income people.

- **Staff Training.**

For welfare staff who primarily think of their own jobs as getting their clients employed immediately, the connection with family planning is not always readily apparent. Staff training can explain the widespread phenomenon of unintended pregnancy and its relationship to poverty; the need for ongoing access to family planning services, and how to discuss reproductive health issues with clients in a way that is supportive and respectful. Training can also help welfare staff know how to make an effective referral for voluntary family planning.

- **TANF funds.**

All of the linkages described above utilize the welfare system infrastructure (e.g. the engagement of welfare staff or the utilization of a welfare office). Another type of linkage is accomplished when TANF funds are expended on pregnancy prevention services outside the welfare system. In this case, the welfare system has relatively little engagement except contracting for those services. These funds can be provided to health agencies, community-based organizations, or other agencies serving low income people in order to develop new family planning or teen pregnancy prevention efforts or to supplement existing ones. States do not have to choose between infrastructure and TANF funding linkages: they can do both.

Brief Highlights from Three States

Part Two of this report looks in depth at three states—California, Georgia, and Washington—to examine the linkages that occur there and to serve as a tool for other states that are considering or might consider similar efforts. Brief highlights follow.

California has a significant number of distinct initiatives, targeting both adults and teens, that are designed to increase access to and voluntary use of family planning services among welfare recipients. Chief among the links in California are:

- A project initiated in 1995 disseminates family planning information to welfare recipients. Run by the state welfare department, the project produces a variety of materials to inform clients that they are eligible for free or low-cost family planning services and to help connect them to providers. It distributes local provider listings that are tailored by county, and on all materials it lists a toll-free number run by the health department that describes family planning services and provides local provider information. County welfare offices and other agencies working with welfare clients can order these materials free of charge.

- Cal-Learn, the state's mandatory program for pregnant and parenting teens receiving welfare, requires school attendance and incorporates family planning as an important component. Cal-Learn provides intensive case management to assist teens in obtaining needed health, education and social services. Case managers discuss family planning with clients and refer them for services at their request. This program is currently being evaluated by the state. A process report was released in 1998, and an impact report is due to be published in January 2000.[27]

- A state demonstration project co-located family planning services in a variety of social services agencies, including a welfare agency. The goal of the project was to expand access to family planning services by providing them in non-medical settings. At the welfare agency, family planning staff provided education, birth control, and other services to clients who wanted them. This project ended in June 1999, and the state plans to use lessons from it to enhance the provision of state-funded family planning clinical services overall.[28]

- A number of family planning agencies have partnered with their local welfare offices to provide reproductive health and family planning education to welfare recipients during job training classes. The agencies were motivated by a "non-traditional" partnership requirement established by the state's Title X (family planning) administrative agency.

- The state-funded family planning program, Family PACT, is primarily designed to provide family planning coverage to low income people up to 200% of the federal poverty level who are ineligible for Medicaid (called Medi-Cal in California). Yet it will provide services to welfare clients receiving Medicaid if they need confidentiality.[29] A companion program to Family PACT, TeenSMART, provides enhanced counseling services to teens in the same income bracket. These programs are currently being evaluated by the state.

While California's statewide and local initiatives are not necessarily coordinated with each other, they demonstrate that linkages between family planning and welfare are viewed as important to the mission of both state and local agencies.

Georgia's link is largely made by tapping the TANF funding stream for an adolescent pregnancy prevention and youth development initiative. The state created the initiative in 1997 in response to its high rate of teen pregnancy, becoming one of the first states to use TANF funds to increase access to reproductive health, family planning, and teen pregnancy prevention services. The Adolescent Health and Youth Development (AHYD) initiative is administered by the state public health agency. It also seeks to facilitate coordination between local health and welfare agencies. Georgia's AHYD provides grants for three types of locally-developed programs which make the link in the following ways:

- Teen centers. These centers provide comprehensive health services, including contraception. They also provide youth development services such as abstinence-based reproductive health education,[30] outreach, home visiting, mentoring, and case management. The centers must give priority to individuals with incomes up to 150% of poverty. They are also required to demonstrate collaboration between the health department and the welfare department. Grants for these teen centers are provided to counties that are most in need of teen pregnancy prevention. In some locations, the centers are co-located with welfare and other social services agencies.

- Male involvement. These programs approach adolescent pregnancy prevention from the male perspective. They offer a variety of services aimed at reducing adolescent pregnancy, promoting abstinence and responsibility among adolescent males, and increasing young fathers' involvement in their children's lives. Sex education is a required component of these programs. Grants are awarded to non-profit or public agencies.

- Community involvement. The goal of these grants is to foster partnerships between organizations and eliminate gaps that occur when organizations address problems independently. The grants also help sustain a variety of programs that are run by partnerships of community organizations and agencies.

Georgia's AHYD initiative is currently being evaluated by the state, with initial results expected in early 2000.

Washington has sought to increase access to family planning services for its low income residents for much of the past decade. It was one of the first states to use state funds to expand family planning coverage for clients who received Medicaid during their pregnancies, doing so in 1993.[31] In 1994, under the law redesigning its welfare system, Washington created a comprehensive initiative linking family planning and welfare.[32] The initiative seeks to provide family planning education and services in every welfare office. It is run by the Medical Assistance Administration, the agency that administers Medicaid and the state-funded family planning program, and it is funded primarily by Medicaid, with a 10% state match. The

Washington experience illustrates how family planning and welfare can be coordinated at a fundamental systems level. The main linkages of the Washington initiative are:

- Itinerant nurses employed by local family planning agencies work on site at welfare offices to provide family planning information, counseling, referrals, and services that do not require a pelvic exam to clients who want them. Clients either access the nurse directly or are referred by a welfare staff member, depending on the site.

- Most welfare offices have a staff member who spends up to 20 hours per week on family planning. This person either supplements the work of the nurse or provides information when the nurse is absent.

- Full-service family planning clinics are co-located with welfare offices in a number of locations.

- The state's welfare agency requires that all welfare case managers refer clients to family planning staff for services; clients are not obligated to follow through on referrals or utilize any services.

- All welfare staff were initially required to participate in a one-time training session relating to family planning and the state initiative. The state now provides yearly statewide trainings and quarterly regional trainings for nurses and family planning staff members.

- A media campaign produces posters, brochures, pens, and condom key chains for distribution to clients through welfare offices. As in California, materials list a toll-free number that people can call for information about family planning services and providers in their local area.[33]

In August 1999, the state published a qualitative study documenting the challenges and strategies of implementing the initiative in five locations.[34]

Each of these states has chosen its own linkage path that reflects state needs and existing programs. The diversity of their approaches reveals that there is a wide range of possible connections between family planning and welfare agencies.

WHY SHOULD STATES CONSIDER LINKING WELFARE AND FAMILY PLANNING?

Linking welfare and family planning addresses significant unmet needs

In the United States, only 39% of women in need of publicly supported contraceptive services receive them. This unmet need for family planning services is a contributing factor to the nation's high rates of unintended pregnancy: nearly 50% of the six million pregnancies each year are unintended, and 8 in 10 pregnancies among teens are unintended.[35] By preventing unintended

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pregnancies, voluntary family planning can help families avoid abortion or the costs of a larger family. Welfare and family planning linkages address this need for family planning in a number of ways:

- **These linkages create new institutions and provide new services.**

In Washington, the state initiative led to the opening of eight family planning clinics. One of them is in a remote area of islands that previously had no clinic. The year after the clinic opened, the abortion rate in the county, which has a small population, dropped from being the seventh highest of 39 counties in the state to being the twenty-third highest.[36] Family planning agency staff believe this drop is directly attributable to the opening of the clinic. In addition, the clinic is the only place[37] that clients can acquire emergency contraception.[38] In other areas of the state, nurses at welfare offices are the only providers of free pregnancy tests.

In Georgia, prior to the AHYD initiative, some counties did not have a teen-centered clinic. In places where these clinics already existed, the initiative allowed for an expansion of services or a combination of clinical services and social services for teens. One county, for example, created a teen center near a non-traditional school for pregnant and parenting teenage girls. The center's two nurses provide family planning and other medical services. More than half of the students have been treated or referred for medical complications, according to the center director, and a significant number have been treated for sexually transmitted diseases that might otherwise have gone undetected.[39]

As well as making clinical services more available, linkages can provide new education services. In Georgia, two of the visited centers provide after-school sexuality education classes for students in school districts that prohibit discussion of contraception during school hours. At one of those sites, AHYD funds are also used to train parents to teach an abstinence-based education program that they then offer in churches, recreation centers, and other sites. In Washington, a nurse and the head of the welfare agency in one town team up to teach sex education in tribal schools serving the area's Native American population. Some welfare offices also send family planning specialists to do outreach and education in low income communities.

- **These linkages help overcome existing barriers to accessing services.**

For low income clients who might not have ready access to transportation, simply getting to a family planning clinic can be a challenge. Providing family planning services on site at welfare offices helps these clients by allowing them to combine a family planning visit with their required visit to the welfare office. Our research in California and Washington also suggests that these on-site services can be valuable for clients, particularly teens, who do not want to be seen entering a family planning clinic.

Another barrier for low income clients is their perception that they cannot afford the services. Nurses who work out of welfare offices in Washington have found that clients often don't know that Medicaid covers family planning or that women up to 185% of the federal poverty level receive state-funded family planning coverage until one year after their pregnancies. They see it as a critical part of their job to ensure that clients know what services are covered and to help

them access these services. California's information project also seeks to alert all cash aid recipients that they are eligible for free or low-cost services.

An additional barrier is lack of knowledge about family planning. Nurses in Washington report that clients are often unfamiliar with birth control options and related issues and so need counseling in order to make informed decisions about their reproductive health. Working at the welfare site affords these nurses the opportunity to counsel clients at length, something they are less able to do at the family planning clinic. California's TeenSMART program also provides enhanced counseling to low income teens in an effort to strengthen clinical services.

- **These linkages reach out to new populations.**

Providing information about family planning services at welfare offices can also assist clients who don't otherwise know where to go for family planning. At one site in Washington, a nurse based out of a welfare office sees approximately 700 patients per year, one-quarter of whom came to her with unintended pregnancies. The vast majority of these women have never received services at the family planning agency's main clinic, yet nearly one-third of the clients who are seen at the welfare site subsequently become clients at the clinic.[40] In California, the information project has twice sent family planning flyers to all cash aid recipients in the state via Medicaid mailings. After the flyer was sent out in February 1999, calls to the toll-free family planning hotline increased by 50% in March.

Family planning providers based at welfare sites in both California and Washington also state that they see many clients who do not have other health care providers, and they are thus able to be a point of entry to the health care system in general by making referrals for other health needs.

Linking welfare and family planning addresses families' needs contextually

An unintended pregnancy can make it difficult for anyone, and for low income people in particular, to carry on with other plans in their lives, such as completing their education, getting or keeping a job, or spending quality time with their other children and family members. Because pregnancy affects so many aspects of individuals' lives, family planning is inherently linked to other social services. Yet few social services programs, including welfare, have traditionally incorporated it. Now California, Georgia, and Washington are changing course in an effort to address clients' needs in a more holistic way.

For instance, California's Cal-Learn program for pregnant and parenting teens uses a case management model to address educational, health, and psychosocial needs. Family planning is an integral part of the program, and trust for discussing reproductive health issues is built over time between clients and case managers.[41] Case managers say that family planning comes up frequently in their conversations with teens in relation to other issues. "It's all interrelated," says one program coordinator, Candace Leverenz.

Reproductive health classes for welfare recipients during job training also demonstrate this new interconnected approach. At sites in both California and Washington, family planning and

welfare agencies have joined to provide these classes, based on the shared knowledge that an unintended pregnancy could derail a client's training or job search.[42]

In Georgia, AHYD-funded teen centers employ "resource mothers" or "resource fathers" to provide mentoring to teens and young adults and to link them with other community services. For example, at one site, resource mothers, who are former welfare recipients, provide home visiting and case management services to pregnant and parenting girls, while resource fathers target young men who have dropped out of school. They assess clients' needs and refer them to other agencies that can address them, whether their needs are for employment, family planning, training, education, housing, medical attention, parenting classes, or something else.

Welfare redesign presents an increased opportunity to initiate links between welfare and family planning

Some linkages between welfare and pregnancy prevention predate the redesign of the welfare system. Others have been created more recently. Whether or not welfare redesign is the direct impetus for the creation of a program, it gives additional steam to these efforts in various ways:

- **Welfare redesign presents a new opportunity to argue that family planning is an important poverty reduction tool.**

Washington's pilot was expanded into a full program under the state's 1994 welfare redesign law. The initiative's supporters were able to win support from their colleagues in the legislature with very little controversy by asserting that family planning was essential for fighting poverty and therefore belonged in the bill. In Georgia, Governor Zell Miller agreed to support the AHYD initiative after acknowledging the potential connection between teenage childbearing and welfare receipt.[43]

- **A new paradigm for welfare workers helps them make connections to family planning.**

The welfare system's new time limits and work requirements are shifting it from a system that was focused on eligibility to one that should consider clients' strengths and weakness relating to work. As a result, welfare staff are turning their attention to services that can help clients overcome barriers to employment and financial self-sufficiency. Caseworkers therefore better understand the importance of promoting family planning to their clients. According to Roberta North, a welfare worker in Washington: "When we were just in eligibility years ago [family planning] wouldn't have fit in, but the way the program is now, we take the client as a whole, and we look at all the barriers to self-sufficiency. Family planning is a large portion of the pie."

- **Family planning linkages can complement other welfare policies related to childbearing.**

California, for example, created its family planning information project after the state passed a family cap policy that denied an increase in welfare payments to recipients who have additional

children. In light of the state's family cap, policymakers wanted to ensure that welfare recipients knew where to access free family planning services.

- **The 1996 federal welfare law created a funding source for family planning linkages.**

The welfare law specifically allows states to use welfare funds for family planning. The law also allows states, for the first time, to spend funds on people who are not receiving cash aid. Thus states can use welfare funds to provide family planning and teen pregnancy prevention services to both cash aid recipients within the welfare system and to others outside the welfare system who might be either pushed into poverty or deeper poverty as a result of an unintended pregnancy.

Georgia spends $11 million in TANF funds annually on the AHYD initiative. California spends $1 million annually in TANF funds on its family planning information campaign for welfare recipients and plans to increase its TANF funding of pregnancy prevention in fiscal year 2000-2001. More than 30 states fund programs to reduce teen pregnancy or non-marital births with either TANF or maintenance-of-effort funds.[44]

States are now amassing large welfare "surpluses," because the amount of funding they receive from the federal government is based on caseload numbers from the early 1990s, and most state caseloads have declined significantly since then. Currently, nearly $8 billion TANF dollars are unspent.[45] While many states report that they are saving these surpluses as "rainy day" funds, Congress periodically threatens to take some of this unspent money back. This may provide an increased incentive for states to spend welfare dollars to expand family planning and teen pregnancy prevention services.

WHAT ARE CENTRAL CHALLENGES TO CONSIDER IN MAKING THE LINK?

There are many reasons for states to initiate linkages between welfare and family planning and pregnancy prevention, yet there are also several challenges in making this step. States considering initiating linkages should be aware of these potential sticking points so that they can address them in developing their plans.

Agency "Cultures"

There is a marked difference in how state welfare and family planning agencies historically have carried out their missions. Welfare is a system largely based on eligibility and participation requirements: clients must conform to these requirements in order to receive benefits, and welfare workers must ensure that clients are meeting them. Family planning providers, on the other hand, offer services that eligible women and men may choose to utilize for themselves for their own health and for family well-being. According to Karen Edlund, acting chair of State Family Planning Administrators (SFPA): "The cultures of the welfare agency and the family planning agency are so divergent, integrating our missions is often a struggle—but it can be done."

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Cultural differences can manifest themselves in the way agencies frame their linkage efforts. In Washington, the family planning program is entirely voluntary, and the Medicaid agency that runs it emphasizes that its goal is to reduce unintended pregnancies among Medicaid recipients. Yet when the state welfare department established the requirement that all welfare case managers refer clients for family planning services, it also adopted a goal of "zero additional births for women on [welfare]."[46] Some people in Washington interpret this goal to mean that the state believes poor women ought not to have children, a limitation of their reproductive rights.[47] Similarly, California's information project initially used a message stating "your body, your family, your responsibility" in marketing family planning services to welfare recipients. The welfare department viewed this as an empowerment message. Some in the family planning community, however, argued that this was a negative approach since it did not acknowledge family planning as inherently a health issue—and that made them wary of partnering with welfare. The state is in the process of changing its message to one that is more health-based.

The cultural difference also means that welfare staff may have difficulty incorporating family planning into their work by providing information to clients or referring them for services. Without a background in health, they may not feel comfortable even raising the possibility of a family planning referral or they may raise it in ways that feel inappropriate to clients. In Washington, although family planning referrals are required, state officials concede that welfare staff perform them infrequently. It is important that family planning agencies recognize this challenge and help welfare staff make this adjustment. But since the two agencies may not view the linkage effort from the same perspective, they can misunderstand each other's actions and needs.

Both welfare and family planning staff interviewed for this report raised this cultural divide as a significant early challenge for linkage efforts. Yet each also said that time and efforts by both agencies can serve to bridge it.

Politics

Another challenge to successful linkages is political opposition. Family planning and teen pregnancy prevention are topics that often attract intense interest and heated debate, and some critics believe that the government should not be involved in providing these services. The AHYD initiative in Georgia encountered this challenge. Although the initial allocation of TANF funds was not contentious, controversy developed as the initiative expanded. A small group contended that the teen centers undermined parental authority by providing confidential planning services to teens, and a number of opponents also focused on the volatile issue of emergency contraception. They tried to limit services and funding for AHYD at the state and local levels.

Although the controversy in Georgia was vigorous, it proved to be surmountable. The state made a number of decisions that may have helped protect the initiative, including devolving substantial decision-making so that counties could tailor programs to the needs and values of their communities. Critics are still vocal, but the initiative has been carried along from one governor to the next. Its funding has steadily increased. Linkages in California and Washington have not generated any significant opposition.

Client perceptions

Providing family planning services through the welfare system can also be a challenge because clients do not necessarily view the welfare office as a supportive environment and might be hesitant to access services there. Dodi Trasher, a Washington resident who left the welfare rolls last year, explains: "Going to the [welfare office] is not an uplifting experience. [Clients] spend so much time there doing paperwork, I'm not sure they would want to get health services there. By the time you come out of that office, your blood pressure is usually raised." In addition, clients who perceive the welfare office as an environment where others tell them what to do may resist family planning outreach if they feel it is being pushed on them. A health educator in California feels this is the case for welfare clients she teaches. She provides family planning education during a required job training course, and she believes that clients would be more receptive if they had more control over the process and could choose to attend the class. This challenge can be exacerbated by the cultural differences between welfare and family planning agencies mentioned above.

Family planning advocates in the states examined in this report say that linkage efforts are able to gain clients' trust by being strictly voluntary and by presenting family planning as a universally valuable health service that is independent of welfare system requirements. Dodi Trasher agrees: "As long as they asked me if I needed it and brought it up as a choice, I wouldn't be offended at all. People should know what services are available, and a lot of people don't know what's out there." Indeed, at one co-location site in Georgia, the teen center has exceeded its clinical capacity and is turning clients away.

WHAT ARE SOME KEY DESIGN QUESTIONS?

To overcome the challenges inherent in linkages between family planning and welfare, and to design programs that correspond to the needs of individual states, policymakers might want to consider the following questions.

What population to target?

An approach that serves all low income families, and not just welfare recipients, offers some advantages. It allows programs to provide services to those who are already in poverty and those who might be pushed into poverty by an unintended pregnancy. When family planning services are directed at a broader population, it can also help deflate the notion that welfare recipients are singled out for different treatment. A universal approach that provides services without regard to income has the potential to gain support from individuals of all incomes. However, since funding is typically limited, a program that serves people of all incomes runs the risk of depleting its funds before assisting those with the greatest need. Georgia has adopted a universal approach focused on its low income population by directing funds to the neediest counties and requiring that priority services be given to people with low incomes. The effect of this decision is that AHYD primarily serves low income, minority adolescents. The state estimates that 98% of the people served have incomes at or below 200% of poverty.[48] Sixty-two percent are African-American and 64% are between the ages of 10 and 19.[49]

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Another consideration is whether to target a specific age group, such as teens. Research shows that eight out of every ten births to teenagers are unintended, that teen mothers are less likely than their female peers to go to college, and that women who begin to receive welfare as teenagers remain longer on the welfare rolls.[50] Thus programs focusing on teens, like Georgia's, direct important services toward a particularly vulnerable population. Teen-focused programs in both California and Georgia provide a wider range of services, including case management and mentoring, than programs for adults that primarily provide reproductive health education and family planning services. On the other hand, programs targeting teens appear more likely to draw political controversy. A state may also already have programs that address teen pregnancy prevention and have fewer services directed toward the adult population's needs. This is the case in Washington. With statistics that show the vast majority of the state's unintended births are to women aged 20-24, and other state programs already devoted to teens, Washington chose not to make any special outreach to teens through its welfare and family planning linkages.

What agencies should be involved in program design and implementation?

The three states' initiatives explored in this paper are each run by different agencies. In Georgia, the public health office administers the initiative. In California, the welfare agency directs two statewide efforts. In Washington, the Medicaid agency leads the initiative. Regardless of the model, in each state the lead agency works with others to capitalize on existing strengths and resources.

In California, the Cal-Learn program for teens is run by the welfare department. Rather than create a new case management system when it developed the program, the welfare department adopted the standards of the successful Adolescent Family Life Program run by the state health department. It also required that counties utilize existing AFLP program sites to provide services to Cal-Learn teens, with a few exceptions.[51] As a result, the welfare department was able to rely on a program with a proven track record and to incorporate community-based organizations and health organizations as service providers.

Washington's initiative also incorporates various agencies. It is driven by the Medicaid agency, which conducts trainings and troubleshoots with individual sites, but it is implemented at the local level by welfare staff. The itinerant nurses are employed by family planning agencies that partner with the welfare offices. This structure has led to some frustration, but it has also ensured that the program is operated by people with family planning expertise. Sharon McAllister, head of family planning at the state health department, says it was essential to her that welfare offices contract with Title X family planning agencies rather than hiring nurses themselves, because these agencies already had strong standards and experience with outreach and education in non-traditional settings.

The broad framework of Georgia's AHYD initiative was designed by the state public health department, but local implementation requires collaboration among agencies at the county level. In part, this is due to the fact that AHYD combines clinical and youth development services. As Michele Ozumba, the former state director of AHYD and the person largely responsible for its creation, explains: "Health department folks are accustomed to providing clinical services. They do not have much experience implementing youth development programs. By the same token,

most youth development programs are unaccustomed to providing clinical services. To fit these two approaches together required creative effort and a great deal of collaboration."

Where should services be offered?

- **The welfare office.**

Offering family planning services in the welfare office can enhance access. This approach provides immediate services for people who might otherwise not access them due to transportation barriers or other concerns. It also reaches welfare and other very low income clients at a site where they are concentrated, thus maximizing outreach and service possibilities to those most in need of publicly funded services. And it can provide an alternative for teens and others who might not want to be seen entering the door of a family planning clinic.

The challenges of cultural difference between welfare and family planning agencies and clients' potential negative perceptions of the welfare system can be disadvantages to locating services at a welfare location. Another disadvantage, which was experienced by a co-location site in Modesto, California, is that clients are primarily focused on immediate needs. Samantha Phillips, head of family planning in the county, says: "Women at the welfare office were dealing with so many issues that family planning was really the last thing they were thinking about—their immediate concern was financial, food, and so on. Consequently, there was a lack of long-term planning in this area."

Sites described in this report show that it is possible to build a successful family planning program in a welfare office despite these disadvantages. At one Georgia teen center that is co-located with a welfare office, the clinic is operating at full capacity and welfare staff use the family planning services for themselves. At a Washington welfare office, clients line up to receive counseling, over-the-counter birth control, or other services from the itinerant nurse. The nurse is well-integrated into the welfare office and appreciated by the welfare staff.

Success may also depend on where and how the co-located family planning services are actually accessed. In some welfare co-locations, such as the two successful ones described above, clients have direct access to family planning providers. In others, such as the Modesto site, clients must ask welfare staff for an escort into the family planning area. An argument for the latter approach is that it is more private for clients, but it makes the effort more dependent on participation by welfare staff. If programs choose direct access, they must allocate space adjoining the welfare office's waiting room or another public space.

A second location consideration is whether to provide services in the welfare office itself or in a separate space in the same building. The former may be more convenient and visible to clients, yet the latter may be perceived by clients as independent of the welfare office and thus more appealing.

A final consideration is the location of the welfare building itself. If the building is geographically isolated, the family planning site is likely to attract only clients who have appointments at the welfare office or other agencies in the building. If the welfare office's

building is in an area that is frequented by low income people, it is more likely to attract other clients from the community as well.

- **Elsewhere.**

Family planning services for welfare recipients need not be located in welfare offices: family planning specialists employed or sub-contracted by welfare offices can approach potential clients at other sites where welfare recipients and other low income people congregate, such as food banks, community based organizations, and child care facilities. Or, as California and Georgia have done for teens, the welfare department can be a partner in developing multi-faceted programs in community-based organizations, schools, or other agencies. One reason to consider locating services outside welfare offices is the rapid, significant decrease in the number of welfare recipients. As caseloads decline, family planning providers may need to spend more time in the community to reach clients who need their services.

Providing education, information, and services outside of welfare offices can also have advantages. In Washington, an itinerant nurse has become the primary reproductive health educator in her small city, teaching classes at schools, court-mandated parenting classes, and clients' homes. In Georgia, a teen center located in a college town partnered with coffeehouses and other local businesses frequented by teens to distribute brochures dealing with sexuality topics; these brochures are also available in the juvenile court and the probation office. In another Georgia city, more clients utilized family planning services at a teen center located in a community based organization than they did at the welfare-based teen center.

How much decision-making should be done at the local level?

Flexibility at the local level permits consideration of the needs, values, and individual circumstances of a community. Involvement of community members in program planning may encourage them to take "ownership" and increase commitment to the program. On the other hand, if a state delegates all program design questions to the local level, individual sites may find themselves reinventing the wheel, and the quality of programs will vary with the degree of local initiative and commitment.

Both Georgia and Washington built significant local decision-making into their initiatives by creating a basic skeleton at the state level and allowing localities to flesh it out. After implementation, agencies involved in these initiatives in both states support this design choice. In Washington, local decision-making has given rise to a program in one city that focuses on education and outreach to young people before they get on the welfare rolls, while other sites have been able to establish co-located family planning clinics. In Georgia, it led to the creation of a teen center adjacent to a school for pregnant and parenting teens in one location and the support of a self-esteem building program for preadolescent girls in another location.

Officials in both states also recognize that this degree of flexibility can be difficult for those at the local level. In Washington, some welfare offices have succeeded in creating flourishing programs, while others have not. Despite the state's efforts to provide family planning information to every welfare recipient, a number of recipients in Olympia, the state's capitol, had

never heard of the program or been asked whether they needed services. Claudia Lewis, who coordinates the initiative for the Medicaid agency, acknowledges that it is uneven across the state: "The question is, how do you mandate something around family planning without limiting their flexibility? How do you make it an everyday activity and not limit creativity? We could have erred in being too flexible in what action we wanted. Now we're working to come up with more consistency."

Participants in the Georgia and Washington initiatives say that technical assistance and guidance from the state are important for overcoming these design and implementation challenges at the local level. Washington published a handbook, now on site at over 90% of the state's welfare offices, that describes the family planning initiative, suggests activities for nurses and welfare staff, and advises how to assess and work with clients. Washington's yearly statewide and quarterly regional trainings also provide family planning staff and nurses opportunities to brainstorm new ideas and air problems. In Georgia, the public health agency did not originally offer much direction about how to combine clinical and youth development services, according to teen center directors in Rome and Macon. Michele Ozumba, who was instrumental in developing the AHYD initiative, wishes that the state had taken more time, perhaps the first year of the initiative, to help local communities with planning and training. She would not have imposed any additional requirements or mandates, but would have had the state "offer more guidance and leadership to help local communities put the foundation pieces in place." In 1998, the state recognized this need and provided seminars on youth development that local programs found helpful.

Striking the right balance between state and local control also requires consideration of the controversy surrounding pregnancy prevention initiatives. In Georgia, delegating decision-making authority to local officials had the perhaps unintended effect of transferring many political trials and tribulations to the local level. Some of those involved with the AHYD controversy believe that more decision-making should have been vested in state officials, whose decisions may be more insulated from controversy because they are often reached in a broader context (e.g. a multi-billion dollar state budget rather than a county level decision about a particular pregnancy prevention program). On the other hand, others in Georgia believe that state officials were subject to as much pressure and scrutiny as local officials were. The right mix of state and local decision-making may vary from state to state, depending on the political climate and the nature of the initiative to be undertaken.

California has quite a different model. Its state-initiated linkage efforts are more centralized, although the family planning information project does work closely with county welfare agencies to create materials that will be useful everywhere in the state. But California also has a number of locally-initiated linkage efforts. For example, many of the education-related projects resulted from family planning agencies approaching their local welfare departments. In one location, an initial approach by the family planning agency resulted in an invitation by the welfare department to embark on a more extensive project to help young people become self-sufficient adults, with a focus on teen pregnancy. Part of the impetus for locally driven initiatives may be that the state's welfare system is county-administered.[52]

That California's various initiatives are not all centrally managed by the state has both a benefit and a disadvantage. The disadvantage is that agencies are often unaware of other efforts at the local level and are therefore unable to benefit from their experience. The benefit is local flexibility for some projects and statewide standards for others: the generation of ideas and projects at the local level allows for particular attention to community needs and avoids state bureaucracy, while the standards for the Cal-Learn program ensure that teens throughout the state receive the same high level of case management.

How much of a system change to make?

- **Far-reaching initiatives.**

Extensive initiatives can have great rewards. As a result of Washington's five-year-old initiative, welfare recipients and other low income people can now access family planning services at three-quarters of the state's welfare offices.[53] And Georgia's decision to combine traditional family planning services with youth development services has led to more comprehensive programs across the state that policymakers hope will provide adolescents with both the motivation and the means to delay pregnancy and childbearing. In 1998, the teen centers served over 8,000 people and the male involvement programs worked with more than 2,000 adolescents.

Efforts that involve fundamental system change are resource intensive; necessitating time, labor and money. They require significant planning, coordination among different agencies, and cooperation by welfare and family planning staff.

People involved in the Washington initiative at both the local and state levels say they cannot overemphasize the importance of training in helping welfare staff integrate family planning into their jobs. The site that many point to as one of the state's most successful requires all staff—including receptionists—to participate in yearly trainings. The most recent training incorporated family planning into a uniform message about self-sufficiency. Positioning self-sufficiency as the core goal of the welfare system, the training provided workers with messages linking employment, family planning, education, transportation, health, and child care to self-sufficiency. This training helped staff to understand the family planning initiative and offered a way they could bring up the topic that was supportive rather than controlling or punitive. "We'd be in the dark without the training," says welfare case manager Roberta North.

Extensive change may also be more viable when it is systematized. Welfare staff in Washington, for example, say the requirement that they refer clients for family planning will remain largely symbolic until it becomes institutionalized. One welfare case manager, Terri Ross, says that she and her colleagues have a lot of material to cover with clients, and many do not think of the family planning referrals. "Until it's mandatory [of caseworkers and], on the computer, it won't happen consistently," she says. The welfare department is hoping in the future to establish a family planning referral mechanism in the computer program that welfare staff use for work referrals.

- **Incremental initiatives.**

Less comprehensive efforts can have an immediate impact on the unmet need for services. In California, the family planning information project and local family planning agencies have used welfare and Medicaid mailings to disseminate information about family planning services. These mailings do not cost the government additional postage, and they reach a large audience. Family planning education for welfare recipients in work training classes is another quick and easy linkage that has been undertaken in California, as is the provision of written family planning information and over-the-counter contraception in welfare offices. Staff training can also be provided as an incremental step to linking welfare and family planning. Such training can increase the effectiveness of referrals and make the most of existing family planning resources, even when the state is not launching a comprehensive linkage effort.

How Should an Evaluation Be Undertaken?

Evaluation provides concrete information to help those involved in these efforts understand where their strengths and weaknesses lie, and to make adjustments accordingly. In addition, it can help deflate political controversy because it documents whether and how effective the program has been and thus helps move debate beyond a rhetorical level. Yet designing an evaluation that captures the impact of these types of linkage efforts can be challenging and time consuming. As Michele Ozumba in Georgia states: "How do you measure who you're reaching with the program? Do you look at outcomes for everyone in the county where the program exists? Everyone in the neighborhood where the program is located? Or everyone who comes into the teen center? What do you compare those outcomes to? Outcomes in other counties or neighborhoods without a program may not be comparable if those communities have different risk factors for teen pregnancy." Georgia began its evaluation after the initiative started. The clamor for answers, however, is outpacing the evaluation. Ozumba wishes the evaluation had been in place before implementation so that preliminary answers could be provided and new sites could be informed by the early results.

CONCLUSION

Family planning is a service needed by the majority of women for much of their lives. For many low income women, it is an unmet need. Fortunately, reflecting the major impact that reproductive health has on other aspects of women's lives, family planning is increasingly being integrated into social services. As the experiences of California, Georgia, and Washington demonstrate, linkages between welfare and family planning are flexible. They can be tailored to meet the individual needs of states and localities, and they can be extensive or incremental, as policymakers wish. Linkages between welfare and family planning offer much rich terrain to explore.

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PART TWO

Making the Link: Three States' Stories

CALIFORNIA

A teen mother who receives welfare discusses family planning options with her social worker as part of a case management program. A health educator teaches welfare clients in job preparation classes about reproductive health issues. Along with their Medicaid cards, welfare recipients receive flyers highlighting a toll-free number for information about family planning services in their area.[54] *These are a few of the ways that family planning and welfare are linked in California.*

In California, a variety of distinct initiatives link family planning and welfare. While the state runs several of these programs, others have been initiated at the county and local levels, and they are administered by different types of agencies. The various efforts are:

- A TANF-funded information campaign aims to help welfare recipients learn about and voluntarily use family planning services.
- A question on welfare applications asks whether applicants want family planning information.
- The mandated program for teen parents receiving welfare emphasizes reducing risk behaviors and includes referrals for family planning services.
- A "non-traditional partnership" effort facilitates linkages between a number of Title X family planning agencies and welfare agencies.
- Family planning is co-located with social service programs for low income people in some sites.
- TeenSMART, part of a state-funded family planning program, provides enhanced counseling to low income teenagers seeking family planning services.

HISTORY AND DEVELOPMENT OF THE INITIATIVES

California's effort to provide family planning information to welfare recipients is not new. In keeping with a longstanding federal requirement, the state's welfare department has been required since at least the early 1980s to: "inform all [welfare] applicants/recipients of the availability of family planning services. For those [welfare] applicants/recipients who voluntarily request such services, the [welfare department] shall provide information and referral for family planning services." [55] To conform to this regulation, the state included on welfare applications a question as to whether applicants were interested in receiving family planning information. Similar questions relate to other health and social services. Applicants are not required to answer the question, nor to access services if information is provided to them.

California: Key Fertility Data

Teen Pregnancy Rate (per 1,000):	125
Rank[1]:	3
Teen Birth Rate (per 1,000):	63
Rank:	15
Unmet Need for Publicly Funded Family Planning Services[2]:	
Percent of All Women:	64
Percent of Teen Women:	68

[1] The rankings of pregnancy rates and birth rates are based on the rates calculated for all 50 states and the District of Columbia. The state ranked "1" has the highest rate.

[2] The definition of women in need of publicly funded contraceptive services includes women aged 20-44 who are in need of contraceptive services and supplies and whose income is below 250% of the federal poverty level, as well as all women younger than 20 who are in need of contraceptive services and supplies.

Source: Alan Guttmacher Institute, *Contraception Counts: State-by-State Information*, August, 1999.

Initially, the state developed a family planning brochure to distribute to applicants who requested information. The brochure was discontinued in the late 1980s, however, and for a number of years county welfare departments were left on their own to procure and distribute information.[56] In 1995, Governor Pete Wilson created the Teen Pregnancy Prevention Initiative. As part of this initiative, the state welfare department was allocated $1 million per year to develop and disseminate family planning information to welfare recipients through what is now called the CalWORKS Family Planning Information Project.[57]

Chris Minnich, the welfare department's current manager of the project, explains that "the impetus for creating it was in part because of welfare reform. A new family cap rule was established that if you were on aid and had an additional child, your aid did not increase because of that child. The administration wanted to make sure, if we were imposing this rule, that recipients knew about and had access to family planning services."

When the project began, state staff quickly learned that most county welfare offices did not distribute family planning materials. In many cases, if applicants requested information, they were told to visit the county health department. As a result, the information project's first step was to develop a brochure entitled "Are you interested in free family planning services?" to tie in

to the question on the application form and provide the welfare worker something to give the client.

At first the project just provided information regarding what family planning services were available, and where clients could access them. However, in 1998, California's new welfare program, CalWORKS, was implemented with an emphasis on work and time limits on aid. "The administration saw it was time to link family planning services with the new requirements by sending a message to ensure that recipients saw family planning as a supportive service that helped prevent an unintended pregnancy, which is a barrier to work," Minnich says. Initially paid for by the state's general fund, the CalWORKS Family Planning Information Project has been funded with federal TANF dollars since July 1998.

"[I]t was time to link family planning services with the new requirements . . . to ensure that recipients saw family planning as a supportive service that helped prevent an unintended pregnancy . . ."

Another major linkage of welfare and family planning also occurred as a result of California's redesign of the welfare system. In 1994, the state created Cal-Learn, a mandatory program for pregnant and parenting teens who receive welfare themselves or through their families. Cal-Learn is designed to encourage graduation from high school or its equivalent; it also includes a clear focus on pregnancy prevention. Cal-Learn provides financial bonuses or imposes sanctions based on school performance; it can pay for supportive services such as transportation, child care, and school supplies for enrollees; and it provides intensive case management to assist the teens in obtaining needed education, health, and social services.

For the case management component of Cal-Learn, the state turned to an existing state-funded program, the Adolescent Family Life Program (AFLP). Initiated in the mid-1980s, AFLP was designed to enhance the education and to improve the health, social, and economic well-being of all pregnant and parenting teens in California. The program seeks to encourage adolescent women and their partners to make use of health care resources and reduce unintended pregnancies, among other goals. Chris Minnich, who is also the manager of the Cal-Learn program at the welfare department, explains why Cal-Learn adopted AFLP's standards: "When Cal-Learn was developed, the department saw AFLP as a successful program that had a track record with pregnant and parenting teens. It was quite an accomplishment for two separate state departments to work together and create the same case management services for pregnant and parenting teens, whether on or off cash aid."

A third linkage between family planning and welfare was created in 1998, when the California Family Health Council (CFHC), which administers Title X funds in California, required that all funded agencies develop "non-traditional" partnerships in an attempt to increase access to services through new avenues of outreach.

As Margie Fites Seigle, head of CFHC explains: "We did the non-traditional partnerships because we felt that [Title X grantees] needed a push or resources to reach out to places where there were low income women who were not receiving services, particularly to job training programs, welfare to work, and day care. The reason why welfare to work is so important is that

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many of these women will soon be working and will no longer be eligible for Medicaid. Hopefully by then the relationships will be established and they will keep coming to receive services under Title X. This will keep them from falling through the cracks." As a result of this initiative, a number of Title X agencies have teamed up with welfare offices to provide education and information to welfare recipients. Other agencies have partnered with other programs serving low income people such as: WIC sites, gang prevention community organizations, jails and prisons, job training programs, and homeless services centers.

The state's First Stop demonstration project also created new linkages between family planning and welfare and other social services agencies. It was created in 1996 by the state's Office of Family Planning to increase access to family planning services by providing them in non-medical settings. The three-year pilot project funded family planning agencies to co-locate with seven non-medical sites: one welfare office, four WIC offices, and two community-based organizations. The demonstration project ended in June 1999, and the Office of Family Planning will use lessons from it to enhance the provision of state-funded family planning clinical services

California: Selected Low Income Fertility Related Policies

Expanded Eligibility for Family Planning[1]	YES
California uses state funds to provide free family planning services to women and men up to 200% of poverty.	
Family Cap Policy:	YES
Client's Individual Responsibility Agreement (Welfare Contract) Can Mandate Family Planning Counseling:	NO

[1] Federal Medicaid law requires states to offer pregnant women with incomes up to 133% of poverty maternity care services, which include family planning services for two months following the pregnancy. States have the option to offer such services to these women with incomes up to 185% of poverty (state "disregard" calculations may result in women with higher incomes actually receiving services). In this chart, expanded eligibility for family planning does *not* refer to services to women between 133% and 185% of poverty. Instead, expanded eligibility refers to:

- The continuation of Medicaid family planning services to women who have exhausted their two months of post-pregnancy family planning services (permissible through a federal waiver);
- The provision of Medicaid family planning services to low income men and women who do not meet the state's regular Medicaid eligibility criteria (permissible through a federal waiver);
- The provision of state-funded family planning services for those ineligible for Medicaid family planning services.

Sources: State Policy Documentation Project, a joint undertaking of the Center on Budget & Policy Priorities and the Center for Law & Social Policy, www.spdp.org. Center for Law & Social Policy, *Individual Responsibility Agreements & TANF Family Life Obligations*, August 1998. *What Counts? Determining Medicaid and CHIP Eligibility for Children*. Ku, L., Ullman, F. & Almeida, R. Urban Institute Press, July, 1999.

overall.[58] At least one of the family planning agencies funded through the pilot project plans to continue the WIC co-location.[59] A similar project has been run by the California Family Health Council with Title X funds since 1997. This program provides services in four non-medical sites: three community centers and one housing authority.

The 1997 expansion of California's state-funded family planning program also had an impact on family planning for welfare recipients, as well as other low income Californians. The new program, Family PACT (Planning, Access, Care and Treatment), provides no—or low-cost family planning services for women and men up to 200% of the federal poverty level who do not have access to Medicaid or private health insurance. All licensed Medicaid providers are eligible to sign up as Family PACT providers; those who do enroll must take a training class and sign an agreement that they will comply with program standards that include providing counseling and reproductive health education to clients. The program is jointly administered by Medicaid and the state's Office of Family Planning, although it is paid for wholly with state funds. The program has expanded coverage for family planning services to a much larger percentage of the low income population in California.[60]

According to Jan Treat, the program manager, Family PACT provides an important safety net for clients moving from welfare to work, since many find low-wage jobs that do not provide health insurance and they often cannot afford private insurance when their transitional Medicaid terminates. In addition, although Family Pact's purpose is to provide coverage to low income clients who are ineligible for Medicaid, the program also benefits welfare clients who are concerned about privacy. It will cover Medicaid recipients if lack of confidentiality would prevent them from accessing services (e.g., someone else in their household receives the Medicaid statements and they do not want that person to know they are using family planning services for fear of abuse or other issues).

In addition to these statewide initiatives, county- and local-level partnerships between family planning agencies and social services agencies exist in various locations. All of these pieces together form an active web of linkage efforts in California.

ELEMENTS OF THE INITIATIVES

Tenisha's Story

"Tenisha" was eleven and pregnant when she entered the Cal-Learn program in San Francisco. She had been raped by a seventeen year-old. As she prepared for the birth of her baby, Tenisha had another responsibility—taking care of her mother, a serious drug addict and Tenisha's only close relative in the area.

Despite the challenges of her life, Tenisha was doing well in school. But she needed guidance and support from adults, and she received this through the case management and other services provided by the Teenage Pregnancy and Parenting Project. TAPP is the San Francisco contract agency for Cal-Learn, the state's mandatory program for pregnant and parenting youth receiving welfare.

After delivering a healthy baby girl, Tenisha met with her case manager, a public health nurse, and a child development specialist to discuss birth control. She had not been sexually active prior to the rape, but now she was. At the meeting, Tenisha decided to use Depo Provera, but the group felt that she needed support in order to go every three months for the shots. The child development specialist agreed to accompany her. First, they researched doctors to find someone Tenisha would be comfortable with, then every three months they made it an outing, going to the doctor's office and having lunch.

For two years, Tenisha regularly visited the doctor for her birth control shots, raised her daughter, and stayed in school. She struggled in school for a time, however, and was helped to get back on track by support from TAPP.

Then her mother decided to move to another state. Within six months of their move, Tenisha was pregnant again. "When she was here and had someone here to help her access reproductive care, she used it," explains TAPP's child development specialist, Naomi White. "When she got to a place she didn't know and was alone with a mother with all kinds of problems, she got pregnant." Tenisha terminated her second pregnancy.

After this experience, Tenisha got back in touch with TAPP staff. They helped provide her with a record of her birth control history and needs, so that she would feel more comfortable initiating a relationship with a new reproductive health care provider. Since then, Tenisha has resumed use of Depo Provera and has graduated from middle school. Her daughter is doing well and her mother, while still using drugs sporadically, is getting support from extended family. Tenisha is fifteen, she has a future.

Information Dissemination

California is a large and diverse state, and many decisions as to how the welfare system operates are made at the county level. A major goal, therefore, of the CalWORKS Family Planning Information Project is to create information materials that will be useful everywhere in the state and to make it easy for county welfare agencies to obtain them.

The project produces a variety of materials: 1) a basic brochure informing clients that they are eligible for no— or low-cost family planning services; 2) a "women's packet" that includes brochures about contraception options, breast cancer, HIV AIDS, abstinence and self-esteem, and sexually transmitted diseases; 3) posters; 4) pens and pencils; and 5) a "family planning local listing" that is customized for every county in the state. The local listing provides the names, addresses and phone numbers of providers in the county who accept Medicaid. All of these

materials are available in English and Spanish. The local listing is available in five additional languages. All of the materials list a toll-free number run by the state health department's Office of Family Planning that describes family planning services and gives local provider information.

Welfare offices can order these materials from the state free of charge. When the project develops a new item, it sends an information notice to all county welfare departments. It is then up to the county to decide which materials it wants to order. As of March 1999, the project had distributed over 600,000 copies of the local listing, 700,000 pens and pencils, and 300,000 women's packets. The local listing, in particular, has been very useful for county welfare agencies, according to project manager Debra Johnson. A year and a half after it was introduced, approximately 45 of the state's 58 counties were using the local listing. Fifty-six counties use the project's pens and pencils. Only one county, Orange, does not use any of the project's materials, because the welfare agency there works closely with its own department of health to provide information.[61]

In Shasta County, the welfare office has sent out the family planning local listing to its entire caseload—over 10,000 people, including Medicaid, food stamps, and cash aid recipients. Each month, the office sends out benefits status reports to all clients; along with these reports it includes a "stuffer" on different topics such as health and housing. One month it sent the family planning local listing as its stuffer in order to reach current recipients, says welfare program manager Steve Grimm. To reach new applicants, the office distributes the pens with application forms and has the local listings, women's packets, and posters in the reception area. The office does not have a policy relating to discussion of family planning or referrals by case managers. If applicants request family planning information, their case managers give them the state materials. Family planning will also occasionally come up when clients and case managers are discussing the family cap policy, Grimm says.

In San Joaquin County, the welfare office distributes the local listing through intake and redetermination packets for welfare clients. Welfare case managers also have the women's packets on hand to distribute to interested clients. In general, staff distribute the materials but do not discuss family planning with clients.

Although the original idea was that the materials produced by the Family Planning Information Project would be used solely by welfare offices, the state has now begun making them available to other welfare-related programs, such as the Cal-Learn teen program and welfare-to-work training programs. In addition, it is now providing them free of charge to other agencies working with welfare recipients, such as community-based organizations, child care resource and referral sites, and school districts. "What we're doing right is being flexible with this. As long as groups work with the cash aid population, they can get it," says Johnson.

> The project twice sent stuffers out to all cash aid recipients inviting them to call the toll-free hotline for information about no—and low-cost family planning services. The number of calls to the hotline statewide increased by more than 50% the following month.

The project has also twice sent stuffers out to all cash aid recipients in the state through Medicaid mailings. The first, sent in the fall of 1996, mentioned the state's new family cap policy as a vehicle for introducing family planning information. The second contained the message "Your body, your family, your responsibility." Both invited readers to call the toll-free hotline "for information about no- and low-cost family planning services, birth control supplies, education, and pregnancy prevention." The second stuffer was sent out in February 1999, and the number of calls to the hotline statewide increased by more than 50% the following month. Staff at the family planning information project believe the increase is attributable to the mailing, since there were no other coinciding statewide initiatives. The project also used a larger version of the flyer in a bus advertising campaign throughout Los Angeles County.

Reproductive health messages can be politically sensitive. "Our message had to work among people with lots of different perspectives. We worked to design something that would be universally acceptable."

Most of the state materials contain messages developed by the project, such as "Your body, your family, your responsibility." The posters with this message bear a photo of a Latino-looking couple smiling at their son. Others in the series stress the importance of thinking ahead to reduce unintended pregnancy: young adults with babies are pictured, accompanied by the message "Think before you act. Everything has a consequence." Chris Minnich of the state welfare agency explains that the messages are intended to be general so as to resonate with all of California's diverse residents. "The populations are very different county to county. Some are very rural, some are urban."

Reproductive health messages can be politically sensitive. "Our message had to work among people with lots of different perspectives," Minnich says. "We worked to design something that would be universally acceptable." The personal responsibility message was tested in focus groups of welfare recipients, and Johnson says they saw it as "an empowerment message: if I can't take care of myself, I can't take care of my family."

However, some in the family planning community take exception to the state's messages. Samantha Phillips, who directs the family planning program in Stanislaus County, says that she finds the women's packet "excellent, a fabulous mechanism for education." But she interprets the personal responsibility message differently than Johnson. "I think the personal responsibility message is a negative, punitive approach. It's similar to trying to get men more involved by imprisoning them for statutory rape. This doesn't work. Language, manner, and approach are so important. We need to congratulate efforts they're making and support them in their endeavors." Cultural considerations must also be taken into account, she says. For example, in her county there is a Cambodian community which "lost a lot of [its] population as a result of the Khmer Rouge. It's reasonable that they want to repopulate. When they have large families, it's not because they're irresponsible, it's because they're seeing it from a different perspective."

During the administration of Governor Wilson, the state also linked its family planning messages to the requirements of the welfare program. Messages included "Job assistance and family planning gave me the help I needed," and "My mommy got a job! Now we can afford to do lots

of things together. Cash aid benefits are temporary... Family planning benefits can last a lifetime." The goal of the materials was to remind recipients of the welfare requirements and to let them know that family planning is a service that is available to them, according to Johnson. The materials made the link so as to let recipients know that an unplanned pregnancy could upset their plans for moving into the workforce.

In 1999, the new administration of Governor Gray Davis changed the direction of the family planning information project. Rather than creating messages specifically targeting welfare recipients, the new administration sought to create universal messages and to focus on supporting reproductive health in general. It has eliminated the personal responsibility and work-related messages. The tentative new message that is being focus-tested prior to final approval, is: "Family planning: making the commitment for a healthy future. Do it for yourself, do it for the ones you love." When a new message is finalized, the state will put it on culturally sensitive posters, magnets, brochures, note pads, carrying bags, and pens and pencils. In addition to changing its message, the family planning information project is planning in the next year to do more outreach to refugees, whom the state has found to be less informed about the fact that family planning is an available service covered by their Medicaid.

In addition to the state effort, some counties in California have disseminated family planning information for many years. For example, a Planned Parenthood agency includes its mailers with welfare checks on a yearly basis in seven counties. This effort was initiated by Planned Parenthood, which produces the mailers; the county welfare offices insert them into the envelopes with the checks and send them out.

Case management and counseling

The Cal-Learn program requires that pregnant and parenting teens receiving welfare attend school or its equivalent, and it provides them with case management services.[62] Four times per year, families with a teen in the program are given bonuses of $100 if the teen's grade point average is a C or higher. If the teen's grade average is below D, or if the teen does not submit a report card or is not attending school, the family is sanctioned $100. Teen parents are mandated into the program through age 18 and the time they spend in the program does not count toward their lifetime limit on welfare benefits.[63] Most of these teen parents are not receiving their own welfare checks but are "nested" teens living with an older relative who is receiving cash aid. As of March 1999, there were slightly more than 12,500 teens active in the program across the state.[64]

In providing case management services, the Cal-Learn program utilizes the standards set by the state's Adolescent Family Life Program. At intake, case managers and clients do a comprehensive assessment and develop a plan for addressing the client's various needs. This is followed by a minimum of monthly contact, quarterly home visits, and quarterly service plan updates. Case managers assist clients in accessing needed educational, vocational, health and psychosocial services. These services can be provided by the program itself or by other agencies in a local network. The maximum number of teens per case manager allowed by the program is forty.

Family planning is an integral part of the Cal-Learn case management program. It is included as an element of teen parents' service plans, and family planning providers are part of each Cal-Learn program's local referral network. Case managers who work with teen mothers in San Francisco say that family planning also comes up frequently in relation to other issues. Lani Schiff-Ross, who runs the case management component of Cal-Learn in San Joaquin County agrees: "Family planning is a real big deal. We're able to give them individualized attention to work through issues like misinformation and discomfort with the topic."

Family planning is an integral part of Cal-Learn case management.

There are three models for Cal-Learn case management: 1) the county welfare department contracts with a community-based organization, hospital, or school that already provides the Adolescent Family Life Program to other pregnant and parenting teens; 2) the county welfare department contracts with a public health agency that already provides the AFLP program; or 3) the county welfare department provides case management services itself.

The case management agency in San Francisco is a community-based organization, the Teenage Pregnancy and Parenting Project. This was one of the original pilot sites for the AFLP program, and it is now both an AFLP and a Cal-Learn site. Clients in both programs receive the same case management, but the funding streams and eligibility requirements are different: AFLP is open to all pregnant and parenting teens independent of family income and is paid for by funds from the bureau of Maternal and Child Health; Cal-Learn is required of pregnant and parenting teens who receive welfare and is paid for by the welfare department.[65] There is also an adjunct to the AFLP program that works with younger siblings of Cal-Learn and AFLP teens. A significant benefit of having the two programs together is that teens can be transferred between them. Charlene Clemens, director of the project in San Francisco, says that families frequently go on and off welfare, and the AFLP program allows case management continuity.

In San Francisco, the program is located in the same building as a school, and there is also a health clinic that is open two days per week. There are no set protocols for making family planning referrals, but case managers do discuss it with every client. They also facilitate family planning by taking clients on field trips to health centers in the community, and one local family planning clinic is staffed by peer health educators from the same organization that provides the AFLP and Cal-Learn case management. Clemens' staff also conducts life-skills groups for teens. One of the most important ways case managers help clients, Clemens says, is by being supportive and non-judgmental. "What we're trying to do is prevent early parenting. Yes, you encourage kids to postpone sexual involvement because of the possibility of pregnancy, issues of HIV and STDs, or because they're not emotionally ready, but there will always be kids who are sexually active. These kids feel that they can talk to their case managers and get support on using appropriate birth control and having healthy discussions about family planning."

"These kids feel that they can talk to their case managers and get support on using appropriate birth control and having healthy discussions about family planning."

One of the important factors in working with these teen mothers, Clemens says, is that many of them have a history of sexual abuse and getting a pelvic exam is quite a struggle for them. This is an example, she says, of why the clients' needs should be addressed comprehensively. She is leery of efforts that isolate family planning from other health and social considerations. She and her staff also shy away from discussing family planning in the context of the welfare family cap policy or work requirements. "We treat family planning as a health issue. It stands on its own as a good thing to do. We don't present it as consequential, as in 'if you use family planning you can be self-sufficient.' A woman's right to have a child should not be linked to economics. What about people who read at the third grade level and will never be self-sufficient? The message we should be sending is: don't engage in risky behaviors, because you're worth it."

Clients in San Francisco appear to appreciate their case management. Even those Cal-Learn teens who receive maximum sanctions for failing to attend school (about 40%) nevertheless show up to see their case managers, Clemens says.

In San Joaquin County, the Cal-Learn and AFLP programs are run by the public health department. As in San Francisco, the case managers make decisions about how to address family planning with teen clients on an individual basis. The primary difference between the two sites is that the San Francisco program is based in a building with other teen services, and case managers often meet with clients on site, while San Joaquin case managers meet with clients primarily in the field.

Case managers in San Joaquin receive reproductive health training from a local health clinic on a yearly basis and raise family planning issues with all of their clients. One case manager, Margaret Jara, sends clients who are very interested in family planning to the local clinic for counseling. She gives booklets to clients who are less open, and then follows up in subsequent conversations. "A lot of clients are reluctant to discuss it at first," she says. "After six months you've hopefully established enough rapport so you can discuss it with them." Jara takes clients to the clinic herself if they don't have transportation or they request that she accompany them.

"A lot of clients are reluctant to discuss it at first . . . After six months you've hopefully established enough rapport so you can discuss it with them."

In Santa Cruz, Cal-Learn is run by the welfare department, and there is no linked AFLP program. If a teen goes off cash aid and the program ascertains that this is a temporary situation, the client can continue to receive case management for one month; teens who leave the program can re-enter within 90 days without forfeiting their chances of receiving a bonus. The program focuses first and foremost on educational goals, because that is the mandate of Cal-Learn. But, as coordinator Candace Leverenz points out: "If their main problems are medical or substance abuse, that's where we focus and then the educational plan relates to that. It's all interrelated."

As at the other two sites, the majority of case managers in Santa Cruz are social workers. The site also has a public health nurse, who does medical visits and carries a small caseload of teens with ongoing major medical needs. Most case managers have preliminary conversations

regarding reproductive health with clients and then refer them to the public health nurse for more in-depth discussion. The public health nurse also does postpartum visits to discuss health matters, including family planning, with clients. Because the Cal-Learn program is based on the AFLP standards, the case management is the same even though it is run through the welfare department rather than an AFLP program site. However, Leverenz says that a downside of having the welfare department where she works run the case management is that the teens associate it more closely with the requirements of the welfare system. It also means that her program is entirely dependent on welfare workers identifying and referring Cal-Learn teens, because Cal-Learn does not have an outreach mechanism. At sites where AFLP and Cal-Learn are together, the AFLP outreach often brings teens into the Cal-Learn program as well.

While there are differences among the three types of Cal-Learn sites, the program is consistent in providing comprehensive services to teens and in ensuring that family planning is considered when assessing their basic health needs.

Data from Cal-Learn statewide indicate that family planning is a service that teens need and are accessing through the program. For all clients active in the program in April 1999, 62% were receiving family planning services or had been referred for such services and an additional 26% did not need services.[66]

In addition to the Cal-Learn and AFLP case management, low income teens in California are provided enhanced family planning and reproductive health counseling through the TeenSMART program. Run by the state's Office of Family Planning and funded by state dollars, TeenSMART is designed to strengthen clinical services for teens. It includes a risk-assessment questionnaire that teens complete on their first clinical visit, a counseling session of approximately an hour, and an additional form that counselors use as a guide for subsequent visits. The state provides TeenSMART agencies with training and technical assistance, and it has published a program manual. The state pays clinics for the additional time they spend with low income clients, although it does not pay for Medicaid clients unless the teen is worried about confidentiality. Slightly more than 50 clinics in the state participate in the program; half of these are also funded to do additional outreach.[67]

At Communicare Health Centers in Davis, teen program coordinator Gabrielle Villa says TeenSMART is wonderful. "The average visit is an hour. We are able to go into a lot more detail and explain a lot more than most teens get at their regular doctors. It makes it easier for them; they are more apt to take birth control and do it correctly." The agency provides the same services to all teens, regardless of whether it is reimbursed by the state. Villa says there are many teens who for confidentiality reasons would not access services if they were billed through Medicaid; it is therefore very valuable that the state pays for counseling and services for these teens. Communicare coordinates closely with the Cal-Learn and AFLP programs: case managers often refer clients for counseling and services, particularly following a recent birth. It also has an outreach and education grant

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through the TeenSMART program. The grant has required it to make linkages with 30 other agencies, and its health educators give presentations to approximately 5,000 teens per year in schools and other settings.

Co-location

In recent years, there have been a number of co-locations between family planning and social services agencies in California. Seven of these, including one welfare site and four WIC sites, were a result of the state's First Stop three-year demonstration project that ended in June 1999. First Stop provided services in non-medical settings, streamlined access to birth control, and emphasized the importance of counseling and service referral. First Stop clients were able to receive certain types of birth control—including barrier methods, oral contraceptives, and Depo Provera—without a pelvic exam. The goal of the program was to reach clients who might not otherwise have access to family planning, provide them with services immediately, and then refer them for future services at traditional family planning sites.

There were First Stop sites at both welfare and WIC offices in Modesto. At the welfare office, the reception area included a display of family planning materials and family planning staff worked three days a week in offices near the waiting room. If clients wanted services, they asked the receptionist, who would then take them into the family planning offices. A health outreach worker would also talk to women in the lobby, letting them know about various health services available to them, including the family planning services in the building. In addition to providing services to clients, the family planning agency did three trainings for welfare staff to familiarize them with the services that were available and suggest ways that they could discuss reproductive health care with clients.

At the welfare office, the reception area included a display of family planning materials and family planning staff worked three days a week in offices near the waiting room.

Samantha Phillips, head of family planning in the county, says that the co-location was valuable because many welfare clients did not have primary care doctors, and the family planning staff could make referrals and appointment for clients with other providers. It was also valuable because many clients without children used the services to confirm pregnancies that made them eligible for welfare. Staff could take the opportunity of the pregnancy test to discuss family planning options. The breast exams it administered were also valuable to clients: during one exam, staff discovered that a client had a lump in her breast and immediately scheduled her for surgery.

On the whole, however, Phillips did not consider the co-location to be a success. The primary reason it did not work, she says, was that "women at the welfare office were dealing with so many issues that family planning was really the last thing they were thinking about—their immediate concern was financial, food, and so on. Consequently, there was a lack of long-term planning in this area." Welfare staff agree with that assessment, and say that the site ended up mainly doing pregnancy tests, which was helpful but not the goal of the project. Welfare staff

point out, however, that the clinic was appreciated by teens. "We had several teens excited because they could come here rather than the clinic," says Liana Mahn, who worked with the project. "The clinic has stigma associated with it, and people would see them going there. Here they could be coming for job resources or to other community agencies."

Another major concern that Phillips had with the welfare co-location was that clients might feel they were being coerced into using the services. "We didn't want it to appear that this was a condition for cash aid because of welfare reform, or for people to be made to feel guilty if they determined not to use the services. You have to be very careful. Programs have to be driven by client need and the perception of how they accept it."

"We didn't want it to appear that [using family planning services] was a condition for cash aid because of welfare reform . . ."

Finally, Phillips felt that it was problematic to isolate the family planning area and require escorts for clients seeking services, in part because the welfare staff "gave the impression that it was 'just one more thing to do.'"

Rather than provide only family planning services at the welfare office, Phillips says she would feel more comfortable—and clients' immediate needs would be better addressed—if there was an ombudsman to help clients navigate the health care system. "This would grease the mechanism of referral. The barrier is not the lack of providers, it's the system," she says.

Data from the First Stop program demonstrate that clients at this site did have a need for family planning services but the co-location was not a successful access mechanism. Among all seven First Stop sites, the Modesto welfare site had the highest percentage of clients who had no primary contraceptive method. Yet it also had the lowest percentage of clients who were dispensed a method, and its clients were the most likely to decline a referral to the full family planning clinic. On the other hand, the site did serve as an entryway into the health care system: it was most likely to refer clients for general medical reasons. Perhaps bearing out the welfare staff's impressions about teens' interest in the program, the site also had a higher percentage of clients under 20 than any of the other First Stop sites.[68]

While the Modesto welfare co-location was somewhat disappointing, the co-location at the WIC site has gone very well. The difference, Phillips says, is that WIC staff are comfortable with the issues, the clients are already coming for health education and so are mentally prepared to discuss family planning, and the clients are not as preoccupied by immediate needs. In addition, there is less turnover among WIC staff, and Phillips provides reproductive health training to them on a more frequent basis. Finally, because they have recently given birth, WIC clients have had a pelvic exam, diabetic screenings, and other health

The co-location at this WIC site has gone very well. WIC staff are comfortable with the issues, the clients are already coming for health education and so are mentally prepared to discuss family planning, and the clients are not as preoccupied by immediate needs.

services in the past year, making it easier to provide them with birth control through a non-medical site. Although the First Stop project ended in June, Phillips is maintaining the co-location with the WIC site.

A number of other family planning agencies have also co-located with WIC. In Stockton, another First Stop site, the family planning clinic oversees the WIC program and has a staff member at an accessible office on site at all times. The two agencies have done a joint transit advertising campaign, and WIC case managers all have family planning posters in their cubicles. Although at first not all the WIC staff were enthusiastic, the family planning agency conducted numerous trainings. Over time, the WIC staff became more comfortable and even began taking advantage of the nurse practitioner on site to ask their own family-planning related questions. During three years of co-location, over 750 people accessed family planning services at the WIC office.

In addition to the First Stop project, several agencies have co-located through a similar program funded with Title X resources. And a few Planned Parenthood agencies in the state have independently co-located with WIC and are working on integration of services.[69]

Education and outreach

Stimulated by a "non-traditional partnership" requirement for receiving Title X funds in California, a number of family planning agencies now offer reproductive health classes for welfare recipients. Other agencies in the state provide these classes based on their own initiative. These education sessions are provided during the job preparation classes that are required for many welfare recipients. Although this means that the reproductive health classes are themselves required rather than voluntary, participants are not subject to sanctions for missing them.[70] On the whole, the partnerships have been initiated by the family planning agencies, which then sign a "memorandum of understanding" with welfare to lay out the roles of both agencies.

In San Luis Obispo, health educators conduct half-hour presentations twice a month for participants in the welfare "job club." The welfare staff person leaves the room during the presentation, to allow participants greater privacy. The health educator informs participants of the full range of reproductive health services offered by the clinic, with a specific focus on family planning. Participants then have time to approach educators to ask private questions, or fill out forms that would be required at their first clinic visit. The health educators find that clients are more likely to visit the clinic if they have already completed the paperwork. Informational materials, condoms, and vaginal contraceptive film are also available to those who want them.

Health educators conduct half-hour presentations twice a month for participants in the welfare "job club." The welfare staff person leaves the room during the presentation, to allow participants greater privacy.

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The class does not make any specific reference to the welfare program or its requirements. Rather, health educators view the presentation as an opportunity to let clients know about a community resource and the services available to them. "We make a big effort to be relaxed," says Janice Fong Wolf, who coordinates the classes for the family planning agency, EOC Health Services. "The key is not to pressure; we really want to make it an education session."

Wolf says that initially the classes focused exclusively on family planning, but that some participants—such as post-menopausal women—felt that the information was not relevant to them. As a result, the classes were expanded to cover the full range of reproductive health. "This is more likely to concern them or, if not, someone in their family," Wolf says.

The project began in January 1999. According to the family planning agency's records, in the first three months, it made outreach contacts with 62 people and provided family planning services at the clinic to 12 people. Its goal for the year is 75 clinical visits.

In rural Nevada County, the county health department teaches two classes for welfare recipients: an initial hour-long class on sexually transmitted diseases, followed two weeks later by one on birth control. The original plan also called for classes on family life skills and positive approaches to parenting. Although not currently part of the curriculum, these components may be added in the future. In addition to written materials on reproductive health, the educator provides a list of county services, including child care, counseling, domestic violence, and housing. She also offers participants five dollar vouchers for local food markets or restaurants if they come to the clinic to access services.

The educator, Felicia Sobonya, says that she allows the class to lead her to topics they want to discuss. But, she says, "the feeling I've gotten from participants is that they're being forced to do something they don't want. It would be better to give them a menu offering options that they could choose among. It would make them feel a little more in control."

"It would be better to give them a menu offering options that they could choose among. It would make them feel a little more in control."

In keeping with Sobonya's suggestion, a class in Stockton gives clients more leeway to select the information they receive. There, the health educator does a 15-minute required presentation to all job club participants, simply describing the services available at the clinic. At the end of the presentation, clients sign up for a subsequent one-hour class on birth control if they are interested. The focus of the class is on how parents could discuss birth control methods and issues with their teenagers. The classes are offered in two languages.

As a result of the partnership initiated through these classes, the family planning and welfare agencies in Stockton have embarked on a larger joint project. The welfare agency has agreed to fund a "community action mobilization program" whose goal is to help young people become self-sufficient adults, with a focus on reducing teen pregnancy. The one-year pilot program will target residents in a census tract that has a high density of welfare recipients and other low income people and a high teen pregnancy rate. The goals of the project are to support pre-teens

and adolescents in choices to promote self-sufficiency; support neighborhood participants in modeling self-sufficiency behaviors for their children; and develop a culturally sensitive vision of what is a sexually healthy community. The community itself will develop the program, with assistance from the health agency.

The community itself will develop the welfare-funded program with assistance from the health agency.

Possible elements of the program include the development of materials to help adults better understand the complexities of teenage pregnancy and the critical function adults perform through role modeling and education, the development of strategies to enhance short and long-term life options for adolescents, and the use of indigenous leaders to promote preventative services and education about sexual health and responsibility. The program will work with many community partners, including teen pregnancy prevention programs, schools, the spiritual community, and the welfare department.

CONCLUSION

In California, the family planning agency and the welfare system have both initiated links. In some localities, further linkages have been stimulated by or made independently of the state initiatives such as county health department trainings for welfare recipients on reproductive health and the community action mobilization project around teen pregnancy prevention. While no superagency manages all of these initiatives, the wide range of initiatives and the investments of different agencies demonstrate a commitment to making the link. Not too long ago, the primary connection between welfare and family planning was a question on the welfare application. Over the last several years the varied agencies at different levels of government have developed programs that provide information, education, counseling and referrals for family planning services to welfare clients. The state is currently conducting an evaluation of the Cal-Learn program, as well as the Family PACT and Teen SMART programs that serve low income clients. Family planning proponents hope that these evaluations will provide information about effective strategies and will serve as an impetus for even more linkage efforts.

GEORGIA

In Macon, Georgia, young mothers bring their children with them to a special school for pregnant and parenting teens. An adjacent teen center provides a variety of services, including family planning, to help these young women continue their education. In Rome, a group of adolescents gather at the teen center each Tuesday evening to discuss abstinence and related topics. They engage in lively role playing, practicing new negotiating and decision-making skills. In Atlanta, a group of mothers and their adolescent daughters gather for a daylong retreat to enhance their relationships.

All of these are part of Georgia's Adolescent Health and Youth Development (AHYD)[72] initiative. AHYD is a growing statewide effort, which taps TANF funds, along with state funds, to provide locally determined pregnancy prevention and youth development activities, including:

- Comprehensive teen centers that combine health services and youth development activities.
- Programs that support young males and engage them in teen pregnancy prevention efforts.
- Resource Mothers and Resource Fathers who provide mentoring and case management services for at-risk adolescents.
- Community involvement in youth development and pregnancy prevention.
- Information sharing and educational initiatives for teens and their families.
- The co-location of family planning services with other social services.

HISTORY AND DEVELOPMENT OF THE INITIATIVE

In 1995, Georgia was among the ten states with the highest rates of teen pregnancies and births. In response to this finding, the Commissioner of the Department of Human Resources (the umbrella agency which houses the TANF agency and the public health agency) appointed a Teen Pregnancy Prevention Steering Committee to make recommendations about how to address the problem. In 1997, this committee proposed that Georgia invest in a comprehensive teen pregnancy prevention program that included both clinical services and youth development activities. Around the same time, state officials realized that Georgia's declining welfare caseloads had created a TANF funding "surplus". The timing of these two events was serendipitous.

Georgia: Key Fertility Data

Teen Pregnancy Rate (per 1,000):	109
Rank[1]:	8
Teen Birth Rate (per 1,000):	68
Rank:	9
Unmet Need for Publicly Funded Family Planning Services[2]:	
Percent of All Women:	56
Percent of Teen Women:	61

[1]The rankings of pregnancy rates and birth rates are based on the rates calculated for all 50 states and the District of Columbia. The state ranked "1" has the highest rate.

[2]The definition of women in need of publicly funded contraceptive services includes women aged 20-44 who are in need of contraceptive services and supplies and whose income is below 250% of the federal poverty level, as well as all women younger than 20 who are in need of contraceptive services and supplies.

Source: Alan Guttmacher Institute, *Contraception Counts State-by-State Information*, August, 1999.

The co-chairs of the steering committee, the head of Georgia's welfare agency and the head of its public health agency, convinced the commissioner of the Department of Human Resources and then-Governor Zell Miller that part of the unspent TANF monies should be used for teen pregnancy prevention. The commissioner and the governor acknowledged the potential connection between teenage childbearing and welfare receipt and agreed to support pregnancy prevention programs to address it. Thus, Georgia became one of the first states to use TANF funds to increase access to reproductive health, family planning and teen pregnancy prevention services.

The initiative supports existing local pregnancy prevention and youth development programs and also facilitates the development of new ones. The state subsidizes the creation of comprehensive teen centers in high-risk counties, but devolves substantial discretion to local officials on the design and implementation of these centers. In addition to sustaining teen centers, AHYD bolsters other local efforts to reduce teen pregnancy.

The initiative got underway through an appropriation in the state's 1997 supplemental budget. The initial allocation included $3.4 million of the state's TANF block grant and an additional $6 million[73] of state funds. Despite the frequently controversial nature of teen pregnancy prevention efforts, the initial allocation did not engender much debate.

In part, controversy may have been avoided because the initiative was clearly linked with the restructuring of welfare, which had both legislative and public support. Additionally, at this early date, there was little awareness about the range of services and activities that TANF funds could support. On the other hand, it was clear that TANF funds could be used for pregnancy prevention efforts and taking advantage of "surplus" funds was appealing.

Controversy began brewing when the initiative expanded in its second year, an election year. During the legislative session in early 1998, additional counties were offered funds to develop teen centers.[74] Officials from a few of these counties protested that the state government was trying to interfere with matters that ought to be addressed only at the local level. They objected to the required provision of clinical services and wanted to use the monies for abstinence-unless-married education. The Commissioner of the Department of Human Resources announced that no county was required to accept the grants, but the public health agency responsible for administering the initiative (hereafter Public Health) continued to require clinical services as one component of the comprehensive teen centers' activities.

Georgia: Selected Low Income Fertility Related Policies

Expanded Eligibility for Family Planning[1]	NO
Family Cap Policy:	YES
Client's Individual Responsibility Agreement (Welfare Contract) Can Mandate Family Planning Counseling:	YES

[1] Federal Medicaid law requires states to offer pregnant women with incomes up to 133% of poverty maternity care services, which include family planning services for two months following the pregnancy. States have the option to offer such services to these women with incomes up to 185% of poverty (state "disregard" calculations may result in women with higher incomes actually receiving services). In this chart, expanded eligibility for family planning does *not* refer to services to women between 133% and 185% of poverty. Instead, expanded eligibility refers to:

- The continuation of Medicaid family planning services to women who have exhausted their two months of post-pregnancy family planning services (permissible through a federal waiver);
- The provision of Medicaid family planning services to low income men and women who do not meet the state's regular Medicaid eligibility criteria (permissible through a federal waiver)
- The provision of state-funded family planning services for those ineligible for Medicaid family planning services.

Sources: State Policy Documentation Project, a joint undertaking of the Center on Budget & Policy Priorities and the Center for Law & Social Policy, www.spdp.org. Center for Law & Social Policy, *Individual Responsibility Agreements & TANF Family Life Obligations*, August 1998. *What Counts? Determining Medicaid and CHIP Eligibility for Children*. Ku, L., Ullman, F. & Almeida, R. Urban Institute Press, July, 1999.

The controversy thus shifted to the local level. In several counties, there were battles in the county commission about whether to take the AHYD funds. Two of the 33 counties offered funds for teen centers refused the grants. In a few of the counties that accepted the funds and developed teen centers, critics fought the provision of certain services.

A small group raised concerns about "parental rights". They contended that the teen centers undermined parental authority by providing confidential family planning services. As one critic asserted: "The State of Georgia's [AHYD] clinics are a serious intrusion on parental rights and are taxpayer funded outlets for disbursement of condoms, diaphragms, birth-control pills and chemical abortion pills to our children; all without parental approval or notification."[75] A number of the initiative's opponents focused on the volatile issue of emergency contraception.

AHYD's critics tried to convince local officials not to provide clinical services at the teen centers. Alternatively, they sought to prohibit services to minors without parental consent, despite a long-standing Georgia statute permitting confidential services for family planning.[76] When the state legislative session began in January 1999, the critics moved the battlefront back to the state level.

The structure of the AHYD initiative permits considerable local discretion. It requires collaboration between agencies and organizations and ensures the involvement of community members. This structure encourages local sites to address and respond to a range of concerns. The ability to tailor each teen center to its community likely helped AHYD's champions overcome the controversy without legislative modification of the initiative.

Even with the tumult, the AHYD initiative continues to grow. Its funding has steadily increased, from an initial allocation of $9.4 million ($3.4 million in TANF funds) to the total 1999 appropriation of $18 million ($11 million in TANF funds). The newly elected governor, Roy Barnes, and legislature also support AHYD, maintaining its funding level for 2000.[77]

The number of grant recipients and clients served continues to expand. In 1998, over 8,000 teens were served in 27 different teen centers. In 1999, 12 teen centers were added, bringing the total to 39. In 1998, 23 AHYD-funded male involvement programs served over 2,000 adolescents. Twenty of these sites were refunded in 1999, and 17 new grants were awarded to facilitate community involvement in teen pregnancy prevention.[78] In addition, AHYD monies were used to give each regional health district the resources to hire a youth development coordinator.

In addition to increasing the amount of funding and the number of sites, the AHYD initiative has continued to provide a variety of services, despite the pressure to curtail them. Public Health maintains the requirement that all approved contraceptive methods be available to clients. The statute permitting minors to have confidential access to services also remains in force. In addition, Public Health has increased its focus on youth development activities, encouraging local sites to hire health educators rather than additional clinical staff.

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ELEMENTS OF THE INITIATIVE

Joe's Story

By age 19, "Joe" was the father of two-year-old "Suzy", but he refused to provide any money for the toddler, arguing with her mother over visitation. Joe felt he was trying to do better than his own father – a man he hardly knew and a man who rarely helped out financially. Joe's mother had gotten welfare when she could not make ends meet – which was often. Joe figured he would help out with expenses if he got to see his daughter.

In January 1999, Michael Randall, the coordinator of Macon's Resource Fathers program encouraged Joe to "do right for the child, despite the issues with her mother." In helping Joe become a better father, the program hopes to not only instill involvement with childrearing but also avert unplanned births in the future. Randall lined him up with a job interview and Joe was offered a job on the condition that he start the next day – but he didn't have the khakis he needed. Randall went into his own closet and donated a pair to the cause. Joe worked for several weeks, but quit because he could not get transportation to the job. Rather than give up on Joe, Randall helped him overcome transportation problems in attending an alternative school and, in May, Joe graduated with a high school diploma.

While in school, Joe visited Suzy daily. With Randall's help, he created a "baby book" and learned about Suzy's development. Randall and the Resource Mother working with Suzy's mother helped the two of them concentrate on their child's needs. Joe began to provide for Suzy as much as he could. Randall also worked with Joe's family to help them access needed services and to provide mentoring to Joe's younger brothers.

Joe decided to enlist in the Navy. Nevertheless, he failed to show for several appointments and even missed a ride from a recruiter who personally came to his home to take him on the 150 mile trip for the interview. Undaunted, Randall convinced the recruiter to make another visit. Once again, Randall's patience and persistence paid off.

Within two months, Joe expects to ship out for basic training. Randall is proud of how far Joe has come. Both men hope the Navy will be the chance Joe needs and will let him be the father he wants to be.

Public Health wanted to ensure that a wide range of services would be available to adolescents and hoped to reach large numbers of youth, particularly those most in need. The agency also sought to balance flexibility and direction. To accomplish these objectives, Public Health made several design choices.

As one of its first choices, Public Health adopted a holistic approach to reducing teenage pregnancy. The AHYD initiative supports a variety of local adolescent health and youth development services – not simply traditional pregnancy prevention curricula – in order to create a network of prevention support services that stretches across the state.

A second consideration involved the question of universal versus targeted access. Public Health envisions the AHYD initiative serving all adolescents: (1) those who are not sexually active; (2) those who are sexually active; and (3) those who are already pregnant or parenting. Although Public Health anticipates such universal access, individual programs are permitted to concentrate

their resources and efforts on the group in its community that is most in need of prevention services and activities. In addition, AHYD programs may serve anyone "at high risk of unintended pregnancy," including adults. Finally, although services can be made available to everyone, Public Health requires that local programs give priority to people with incomes up to 150% of poverty.[79]

A third deliberation dealt with the question of whether to focus efforts on the counties with the greatest need or to provide funds to all counties in the state. Public Health struck a balance between these two approaches by offering three types of grants, one that targets particular counties and two that are open to all on a competitive basis:

Teen centers. These centers are to be located in "priority" counties, counties most in need of pregnancy prevention.[80] Although Public Health provides basic guidelines for use of AHYD funds, the county health department[81] has considerable discretion in program design and implementation. In general, the funds must be used to provide comprehensive health services, including contraception, in non-traditional sites (i.e. outside the health department facility) during non-traditional hours (i.e. evenings and weekends). The funds must also be used to provide youth development services such as health education, abstinence-based sexuality education, outreach, home visiting, mentoring and case management.

Comprehensive Teen Centers Must:

- Demonstrate collaboration between the health department & the welfare office
- Utilize adult and teen advisory committees
- Give priority to individuals with incomes up to 150% of poverty
- Provide, directly or through formal referral arrangements, all approved methods of contraception
- Be abstinence-based
- Follow federal and state prohibitions regarding abortion services
- Avoid supplanting local funds

Male involvement. Planning grants of $10,000 and operational grants of $30,000 are awarded, through a statewide competition, to local non-profits or public agencies that "approach adolescent pregnancy prevention from the male perspective". These programs offer a variety of services aimed at reducing adolescent pregnancy, promoting abstinence and responsibility among adolescent males and increasing young fathers' involvement in their children's lives. Grantees must develop a collaborative with other community

agencies and organizations to ensure they address a wide range of the participants' needs.[82]

Male Involvement Program Required Components:	*Male Involvement Program Optional Components:*
• Sexual Responsibility • Sex Education • Conflict Resolution • Parenting Training & Education • Life Skills	• HIV/STD Prevention • Violence Prevention • Mentoring • Peer Leadership • Employment Training & Assistance • Other Prevention Activities

Community involvement. Community involvement grants are used to foster partnerships between organizations and to eliminate service barriers and fill gaps that result when different agencies and organizations address problems independently. The funds are intended to support "process" activities, in addition to specific programming. Community involvement monies help sustain a variety of programs (including mentoring, tutoring, after school activities and summer camps) that are run by partnerships of community organizations and agencies.[83]

A final consideration was the issue of devolution. Public Health could have chosen to use TANF funds to run an adolescent health and youth development program from the state office. On the other hand, it could have distributed the funds directly to the counties, using some sort of population-based formula, and delegated complete control over program design and implementation to local communities. Instead, Public Health selected a middle ground. The agency set certain minimum requirements, including that its local health departments collaborate with welfare agencies, but left most programmatic decisions up to local policy makers.

An example of the balancing between state and local decision-making can be seen in the Resource Mothers component of the initiative. Public Health anticipated that teen centers would hire former welfare recipients as "Resource Mothers" to provide a valuable link to at-risk adolescents in the community. However, initial guidance from the agency did not mandate the hiring of such employees. Rather, it was expected to be a natural outgrowth of the required collaboration with the welfare agency. When teen centers failed to include Resource Mothers in their programs or sought to engage these employees in clerical or janitorial services, Public Health intervened and sent local sites back to the drawing board. Ultimately, the agency drafted a job description for Resource Mothers. Now all teen centers employ Resource Mothers to offer some sort of outreach, mentoring, case management or education, although the specifics of these services remain within the discretion of the local teen centers.

The balance between state and local decision-making can be delicate. The substantial local discretion allowed local sites to be creative and to tailor programs to the needs and values of their communities. While those involved at the local level appreciate this flexibility, some would

also have liked more state guidance early on. For example, Marilyn Ringstaff, the center director in Rome wishes the state had offered more support in the way of technical assistance to get the program up and running. Ringstaff has been working with another site in an adjacent county to share experiences and knowledge, but she wishes the state had helped organize such information sharing and offered more guidance early on.

> The balance between state and local decision-making can be delicate.

The center director in Macon, Susan Joanis, echoes these sentiments. "At first, the state office for AHYD didn't give a lot of direction about how to combine youth development activities with clinical services. Last year they did seminars and went piece by piece spelling out what type of skills training and curricula further youth development." Joanis found this information sharing and guidance useful and wished it had come earlier in the program development.

In addition to creating a need for technical assistance, devolution to the local level may have unwittingly shifted political pressure to local officials who were less able to withstand it. "The heat at the local level was intense in some communities" according to one observer. Elizabeth Appley, legislative counsel for a number of advocacy groups supporting AHYD, believes that "vesting responsibility for sensitive issues involving teen pregnancy at the state level helps local decision-makers withstand community pressure."

Others do not view state directives as creating sufficient political cover. Marilyn Ringstaff notes that even state legislators "must deal with the community they live in." These legislators are "listed in the local telephone directory and people don't hesitate to call them up."

On the other hand, state legislators frequently address controversial issues within a larger context. For example, they vote for or against a multi-billion dollar budget, of which the allocation for a pregnancy prevention program is only a small part. Appley explains that voting in favor of such a budget proposal can "be defended as necessary to avoid killing a whole program over a single policy disagreement."

Georgia's design choices (e.g. adopting a holistic approach; utilizing universal, but prioritized access; focusing on at-risk counties, but allowing all counties to compete for funds; and devolving much, but not all, of the decision-making to the local level) resulted in sites with quite a few similarities, but many differences.

LOCAL IMPLEMENTATION

The following describes three different AHYD-funded communities and illustrates variations in local program design. All use TANF funds, through AHYD, to enhance teen pregnancy prevention efforts, but they utilize the funds in different ways.

Macon/Bibb County

Macon/Bibb County was designated a "priority" county and thus received funds for a teen center. This teen center is located near a school for pregnant teens and teen mothers. The school, which opened in August 1997, is a joint project of the local school board, the county welfare office and a private behavioral health care treatment center.[84] The welfare office and the health department also combined forces and funding to create the teen center. Several months after the center opened, a local public hospital joined the clinic partnership.

The welfare office and the health department also combined forces and funding to create the teen center. Several months after the center opened, a local public hospital joined the clinic partnership.

Attending the school is voluntary. The choice is available to any pregnant teen or teenage mother in the county. The school can accommodate up to 75 young women and generally operates at full capacity. Thus, at any given time, about half of the pregnant or newly mothering teens in the county enroll in the school. Students can attend the school for two semesters and then they transition back into their home school or into an alternative school with flexible scheduling options.

The students receive the regular county school curriculum and then are required to participate in an "extended day" program four days per week; an additional hour of education covering: family planning, HIV/STD prevention, parenting, child development and relationship dynamics. Teen parents who receive TANF assistance, but who are not enrolled in this school, are also required to attend the extended day program, unless they are working.[85] The center added the hour to the end of the school day because the school board does not permit discussion of contraceptive utilization during school hours, even in this school for pregnant and parenting teens. On Fridays, when the extended day program does not run, the school often provides social activities.

Two nurses at the neighboring teen center supply both the mothers and their children with basic medical services, including family planning services. Students can also obtain services from the WIC office next door.

Many social services are co-located near the school. While attending school,[86] the students receive on-site daycare for their children; much of it provided by TANF recipients in work experience placements. Two nurses at the neighboring teen center supply both the mothers and their children with basic medical services, including family planning services.[87] Students can also obtain services from the WIC office next door.

On-campus welfare caseworkers try to connect the students to other social services in the community. Few of the students receive TANF assistance (either on their own or as members of their parent's household); indeed, they are discouraged from enrolling in the TANF program. The caseworkers try to help the teens find alternatives to drawing TANF assistance and assist

them in developing plans for the future. The caseworkers also encourage the young mothers to enroll themselves and their children in Medicaid, and most do.

As part of the effort to keep teen mothers from needing to enroll in TANF, the center director has arranged for local church ministries, community groups and social service agencies to donate baby clothes, toys, furniture and other similar items to the school. The students earn "Baby Bucks" for engaging in "positive behaviors" and then, once a week can spend this simulated money to "purchase" the donated items. In addition, the young women are often referred directly to a local church for items not available in the "Baby Bucks" store or for monetary assistance to meet financial obligations such as rent and utilities.

The students receive a variety of other supportive services through the AHYD funded Resource Mothers component of the program. These former welfare recipients receive three weeks of training on communication skills, interviewing techniques, assessment methods, and networking. Then, the Resource Mothers are employed to provide home visiting and case management services to the students for two years after they leave the school. The Resource Mothers provide moral support and serve a liaison function, linking the young women with social services in the community.

In addition to the teen center, Macon-Bibb County uses AHYD funds to support a male involvement program run through the local health department. The program has three components: (1) a Resource Fathers initiative; (2) a male-only health clinic; and (3) sexuality education training.

Resource Fathers provide mentoring, home visitation and case management to young men – not just teen fathers – in the county. The program began as the outreach effort of a single health department employee who was troubled by the paucity of support given to young men in the community. This employee went out onto the streets and tried to get young males to come into the health department for care. He also attempted to connect them with resources and services in the community. With the advent of AHYD, his individual, volunteer efforts blossomed into an outreach program. One of the goals of the program is a reduction in adolescent pregnancy.

Guiding Tenets of the Resource Fathers initiative:

- Go to where the client feels comfortable – e.g. recreation centers, homes, or the street
- Be holistic – develop a plan addressing multiple needs, not one problem in isolation
- Make clients partners in the decision-making – have the client identify & prioritize needs
- Offer extensive follow-up – at least one year for client & those he interacts with

Three full-time Resource Fathers now offer a variety of services to adolescent males between the ages of 10 and 19. The program targets those who have dropped out of school, but is open to any young man "in need". Resource Fathers provide individual assessments of their clients' needs and then link them with other agencies and providers who can address those needs, whether the needs are for employment, training, education, family planning, housing, medical attention, parenting classes, or something else entirely. The program is quite fluid and flexible in its design.

The adaptability of the program and the dedication of its staff contribute to its apparent success. For example, one of the Resource Fathers brought applications for summer employment to a local recreation center to make the application process more accessible. As he visited with the teens who were filling out the applications, the Resource Father realized that the young men did not really know how to complete the forms. As a result, he initiated an impromptu class on job application.

Another strength of the program flows from the valuable relationships Resource Fathers have forged with local school officials, employment training and placement contractors, juvenile court judges, probation officers, Head Start providers and recreation department staff. According to the coordinator, about 40% of the young men referred to the program come from the local job-training program. Approximately 20% of the program's referrals come from local schools. Another 15-20% come from juvenile court. In fact, as of February 1999, the juvenile court is probating first time offenders directly to Resource Fathers. Additionally, a number of young men are referred to the program by their parents.

Resource Fathers have forged valuable relationships with local school officials, employment training and placement contractors, juvenile court judges, probation officers, Head Start providers and recreation department staff.

Resource Fathers accompany their clients to job interviews, court appearances, and meetings with probation officers. They provide moral support (and frequently transportation) to help teens succeed in these challenges. They also offer reassurance and confidence to the employers, judges and probation officers, who are often more willing to "take a chance" on an adolescent who has the ongoing support of a Resource Father. The employers, judges and probation officers know that they can call upon the Resource Father if problems arise.

The program, which started in the Fall of 1998, hopes to serve 350 young men. To date, Resource Fathers have provided complete case-management services to 120 teenage males. Forty of these adolescents who were unemployed, now have a job. Thirty-five have enrolled in a GED program and a few who were homeless have found shelter.

The second component of the male involvement program is a male clinic. This clinic is not funded with AHYD dollars, but with general health department funds. However, the administrator of the county health department believes that the availability of AHYD funds to support the outreach efforts of the Resource Fathers allowed him to leverage existing personnel and funds and recruit volunteer physicians to staff the clinic. The clinic targets young men

between the ages of 10 and 24 and offers them a variety of medical services. Since its inception in September 1998, the clinic has served approximately 160 young men and staff hope to serve more young men in the future.

Sexuality education comprises the third component of Macon's male involvement program. In order to increase access to sexuality education, the local health department is using AHYD monies to develop a one-day "train the trainer" program. The training will teach 50 parents in the community how to train other parents to provide the abstinence-based Postponing Sexual Involvement curriculum. Each of these parents pledges to train an additional 150 parents who will then offer the curriculum in churches, recreation centers and other community sites which opt into the program.

The training will teach 50 parents in the community how to train other parents to provide the abstinence-based Postponing Sexual Involvement curriculum.

Rome/Floyd County

Floyd County was also designated a priority county and thus receives funds for a comprehensive teen center. Unlike Bibb County, which focuses exclusively on teen parents, the center in Rome tries to address the needs of all teens, those who are sexually active, those who are not sexually active, as well as those who are already parents.

The center offers all approved family planning services on-site and treats sexually transmitted diseases, minor gynecological problems and minor illnesses. The services are available to both teens and adults. In fact, slightly more than half the clinical clients are women who are 20 or older. However, the clinic is teen focused and is available solely to teens between 3:00 and 7:00 each afternoon.

The center is located in an old hotel in the heart of town. The welfare office and other social service offices are located in the same building. This co-location results in a substantial number of clinic visits from not only TANF recipients but also caseworkers. In fact, the clinic is so popular that it must now turn clients away; in order to meet the adolescent demand for services, the clinic is not accepting new adult clients.

The welfare office and other social service offices are located in the same building. This co-location results in a substantial number of clinic visits from not only TANF recipients but also caseworkers.

In addition to clinical services, the teen center provides sexuality education. A Resource Mother and a health educator offer abstinence-based education classes weekly at the center. The classes are highly interactive, utilizing both discussion and role playing to engage the participants. Floyd County public schools offer a sexuality education curriculum, "Managing Pressures Before Marriage," that precludes discussion of contraceptive utilization. Thus, the Rome center's educational component, like the one in Macon, can supplement this school-based education by addressing students' questions that are not covered there. In addition to these

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ongoing, on site abstinence-based classes, center staff are invited to make presentations and teach throughout the community.

To complement its clinical and educational services, the teen center in Rome employs a multi-pronged information dissemination strategy. Rome is a college town and as a result has a number of coffeehouses where adolescents congregate. The teen center designed brochures dealing with a variety of sexuality topics ranging from abstinence to family planning and HIV/STD prevention. These brochures are available in the coffeehouses and other local businesses frequented by teens. They are also available in the welfare office, the juvenile court, and the probation office.

In addition to distributing brochures, the center disseminates information through monthly meetings of a coalition of youth-serving agencies. The teen center director keeps other coalition members apprised of the services available at the center and educates them about current family planning and reproductive health issues.

This regular contact and information sharing facilitates referrals. Since coalition members are familiar with the services offered by other members, referrals back and forth are frequent. For example, the teen center works closely with staff from two home visiting programs for at-risk mothers. The center provides family planning counseling and contraceptives to reduce unintended repeat pregnancies among these mothers, many of whom are teens. In addition, welfare caseworkers have familiarity with the center's clinical services because many of them visit the clinic to meet their own individual family planning needs. This personal acquaintance with clinic staff and services also expedites referrals.

The teen center also provides case management services. The Resource Mother offers clients moral support and encouragement, follows up with those who miss clinic appointments, and acts as a liaison connecting teens with other community services (e.g. housing, GED classes, etc.).

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In addition to using AHYD funds for its teen center, Floyd County uses AHYD monies to facilitate the collaboration and coordination efforts of the youth-serving coalition. An AHYD grant also supports one of the coalition's youth development activities, the "Rites of Passage" program which is designed to develop healthy attitudes among preadolescent females. The volunteer leaders of the Rites of Passage groups are women from the community who serve as role models and mentors for the girls. With the advent of AHYD, four new girls' groups were initiated.

Atlanta/Fulton County

Like Floyd and Bibb Counties, Fulton County was designated a priority county and allocated funds for a comprehensive teen center. Fulton County used the funds to support three centers. One is located in a community based organization. A second is housed in the county hospital and the third is sited within a county welfare office.

A sign at the entrance to this welfare office indicates that a teen center is on site. However, this sign is a bit misleading. There is no distinct center as there is in Macon and Rome. Instead there is a health educator in the welfare office and a mobile medical van that periodically visits the parking lot.

In the wake of Georgia's welfare redesign, (prior to AHYD) this particular welfare office instituted mandatory family planning education for TANF recipients.[55] A health educator from the county health department taught these classes. When the AHYD grant became available in July 1997, the health department decided to use a portion of the funds to place a health educator in the welfare office full-time. The health educator now teaches three classes, which are mandatory for welfare recipients and their children aged 10 to 19.

One class, for adult TANF recipients, covers family planning and HIV STD prevention. The other two classes are for the children of TANF recipients, male and female. Both classes are abstinence focused, but the class for older teens also mentions contraceptive options and alerts participants to the availability of clinical services, while the class for kids aged 10 to 12 does not discuss contraceptives. The 60- to 90-minute classes are interactive, utilizing discussions and role-playing. TANF recipients who fail to attend the mandatory classes or fail to ensure that their children attend the classes can be sanctioned with a cut in their assistance grant. The health educator estimates that since the program's inception, only about one-half of the TANF recipients attended their scheduled classes. However, no one has been sanctioned for failing to attend. The welfare agency and the health educator utilize a conciliation process for those who don't show up for a scheduled class. Generally, after that process, people who initially failed to attend and participate in the class.

In addition to the classes, the health educator tries to utilize a broader information dissemination education campaign. Since the health educator's budget was too limited to conduct more community-wide events, she convinced a group of youth-serving agencies to pool their resources and tap their respective networks of supporters to provide outreach and education in the community. This group put on a teen summit, conducted a mother-daughter retreat, and presented a speakers forum.

In addition to providing education and information, Fulton County employs a co-location strategy. A portion of the AHYD grant helps support a mobile health clinic. This van travels to various sites in the county providing primary medical services, including family planning. The building that houses the welfare office is one of the stops on the van's route. This building also contains mental health, substance abuse and mental retardation services and the Department of Labor's employment assistance services. A satellite clinic of the county hospital is located across the parking lot, although this clinic does not provide family planning services. The nurse

practitioner who staffs the mobile clinic is able to complete WIC applications and provide an initial supply of prenatal vitamins. She is also able to enroll pregnant women in Medicaid using presumptive eligibility. Thus, clients can access a variety of social services at this one site.

Despite this apparently convenient location, the mobile van serves fewer clients than expected at the welfare office site. In 1998, about 25 to 30 people per month sought family planning services while the van was parked in front of the welfare office. Almost all of the people seeking family planning services were adults; on average, 20 to 25 adults and five teens sought care each month. In 1999, van utilization has dropped considerably. The nurse practitioner who runs the clinic estimates that each month she sees about 10 family planning clients at the welfare office, most of them adults.

The nurse practitioner who staffs the mobile clinic is able to complete WIC applications and provide an initial supply of prenatal vitamins. She is also able to enroll pregnant women in Medicaid.

CONCLUSION

Georgia tapped into TANF's flexible funding stream to take on the daunting challenge of teen pregnancy. The AHYD initiative knits together a system of supports (including clinical services, education and mentoring) for adolescents across the state. The structure of the initiative, which grants significant discretion to local officials, facilitated local creativity and innovation, but also raised the specter of inefficiency. To avoid sacrificing efficiency for the sake of ingenuity, the state began offering technical assistance and guidance in 1998. The initiative continues to evolve as state and local officials learn more about combining clinical services and youth development activities.

Controversy frequently envelops efforts to reduce teen pregnancy and AHYD was no exception. The initial allocation of TANF funds was not contentious, but vigorous protest developed as AHYD expanded. Nonetheless, the controversy proved to be surmountable. The state's decision to devolve substantial decision-making to the local level permitted counties to tailor their programs to the needs and values of the community. The selection of universal, but prioritized, access may have bolstered local programs' resistance to attack by concentrating on those in greatest need and simultaneously allowing services to others. In addition, the initiative's focus on collaboration may have garnered new allies for pregnancy prevention and youth development programs. Finally, the decision to conduct a statewide evaluation of the initiative, the initial results of which are expected early in 2000, should provide a concrete measure of effectiveness and may help move debate beyond the rhetorical level. Georgia's choices, or some combination of them, prevented controversy from derailing the initiative. Indeed, AHYD has flourished; steadily expanding its funding allocations, number of sites, number of clients served, and types of services offered and surviving into a new administration.

WASHINGTON

A nurse practitioner and the head of a welfare office team up to teach Native American students about reproductive health. Walk-in clients receive pregnancy testing and birth control on site at welfare offices. The welfare staff informs clients that family planning is available and refer those who are interested to nurses. These are all results of Washington's effort to introduce family planning into every welfare office in the state.

Washington's initiative was created by a 1994 law revamping the state's welfare system. It requires that all prospective and current welfare recipients be provided with family planning information and assistance by the welfare department, and it allows for local flexibility in designing a program that will meet community needs. Whether welfare recipients choose to utilize these services is strictly up to them. Washington has no family cap policy and no sanctions relating to family planning. The state's initiative to link family planning and welfare is both comprehensive and ambitious. Its goal is a fundamental system change to incorporate family planning as a support service for welfare recipients.

Basic characteristics of the initiative are:

- An itinerant nurse is on site at most welfare offices to provide family planning information, counseling, referrals, and services that do not require a pelvic exam.
- A welfare staff member spends 20 hours or more per week on family planning at most offices. This person either supplements the work of the nurse or provides information when the nurse is absent.
- Family planning clinics are co-located with welfare offices in eight locations.
- The state welfare agency requires that all welfare case managers refer clients to family planning staff for voluntary services.
- A media campaign produces posters, brochures, pens, and condom key chains for distribution to clients through welfare offices.

The initiative is funded and administered by the Medicaid program.[89]

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HISTORY AND DEVELOPMENT OF THE INITIATIVE

Washington's links between family planning and welfare grew out of a concern for healthy pregnancies among low income women. In 1989, Washington raised its Medicaid eligibility level for pregnant and post-pregnant women to 185% of the federal poverty level, following a federal law allowing states to do so. In 1993, it used state funds to provide ten additional months of family planning services to the "pregnancy-only" Medicaid population, making it one of the first states to expand family planning coverage beyond two months post-pregnancy.[90]

Washington: Key Fertility Data

Teen Pregnancy Rate (per 1,000):	85
Rank[1]:	32
Teen Birth Rate (per 1,000):	45
Rank:	33
Unmet Need for Publicly Funded Family Planning Services[2]:	
Percent of All Women:	52
Percent of Teen Women:	48

[1]The rankings of pregnancy rates and birth rates are based on the rates calculated for all 50 states and the District of Columbia. The state ranked "1" has the highest rate.

[2]The definition of women in need of publicly funded contraceptive services includes women aged 20-44 who are in need of contraceptive services and supplies and whose income is below 250% of the federal poverty level, as well as all women younger than 20 who are in need of contraceptive services and supplies.

Source: Alan Guttmacher Institute, *Contraception Counts: State-by-State Information*, August, 1999.

At the time it raised Medicaid eligibility in 1989, the state created the First Steps program. The basic maternity services provided by First Steps are available to all pregnant and post-pregnant women who receive Medicaid. Pregnant women are referred to a First Steps social worker, who assesses their needs—including family planning needs—and refers them to health care providers, the WIC nutrition program, and other services. Those clients deemed to be at risk also receive ongoing case management.

While facilitating women's access to maternity care, the First Steps program also instituted Washington's first systematic family planning referral for Medicaid clients. Since First Steps provided family planning referrals only to those women who were pregnant or had been pregnant in the last year, it failed to reach the larger universe of women in need of family planning and receiving Medicaid.

State data showed that a large percentage of the Medicaid-eligible population was at risk for unintended pregnancy. While the unintended pregnancy rate was high for the state as a whole—55% of all pregnancies—it was higher for low income women. More than two-thirds of births to women on cash aid resulted from unintended pregnancies.[91] One factor was a lack of access to services: less than half of women in need of publicly funded contraceptive services in Washington received them.[92]

With the goal of increasing access to family planning services for all Medicaid clients, in the early 1990s the state's Medicaid[93] and family planning agencies held a series of community

meetings with service providers. Among the ideas generated at the meetings[94] were a number that linked social services agencies and family planning. These included:

- Co-locate family planning and social services agencies;
- Outstation welfare/Medicaid eligibility workers in schools, clinics, and hospitals;
- Station a nurse at the welfare office to do health screenings and provide information;
- Develop a family planning case management model;
- Provide additional family planning clinic sites at or near welfare offices
- Station an information and referral worker in the welfare office to facilitate clients' access to other outside services.

Medicaid agency staff also served on an advisory committee with state legislative staff to discuss family planning for substance abusers. Representative Helen Sommers, who initiated the group,

Washington: Selected Low Income Fertility Related Policies

Expanded Eligibility for Family Planning[1]	YES
Washington uses state funds to provide free family planning services to women for 10 months beyond the two months of post-pregnancy services available under Medicaid.	
Family Cap Policy:	NO
Client's Individual Responsibility Agreement (Welfare Contract) Can Mandate Family Planning Counseling:	NO

[1] Federal Medicaid law requires states to offer pregnant women with incomes up to 133% of poverty maternity care services, which include family planning services for two months following the pregnancy. States have the option to offer such services to these women with incomes up to 185% of poverty (state "disregard" calculations may result in women with higher incomes actually receiving services). In this chart, expanded eligibility for family planning does *not* refer to services to women between 133% and 185% of poverty. Instead, expanded eligibility refers to:

- The continuation of Medicaid family planning services to women who have exhausted their two months of post-pregnancy family planning services (permissible through a federal waiver);
- The provision of Medicaid family planning services to low income men and women who do not meet the state's regular Medicaid eligibility criteria (permissible through a federal waiver)
- The provision of state-funded family planning services for those ineligible for Medicaid family planning services.

Sources: State Policy Documentation Project, a joint undertaking of the Center on Budget & Policy Priorities and the Center for Law & Social Policy, www.spdp.org. Center for Law & Social Policy, *Individual Responsibility Agreements & TANF Family Life Obligations*, August 1998. *What Counts? Determining Medicaid and CHIP Eligibility for Children*. Ku, L., Ullman, F. & Almeida, R. Urban Institute Press, July, 1999

saw family planning as an important tool for decreasing unintended births to substance abusers and for increasing self-sufficiency among low income women in general. Armed with ideas from the community meetings, Sommers, who was chair of the House appropriations committee, proposed using Medicaid match to fund a pilot welfare family planning project located at welfare offices.

In 1992, Washington put up $80,000 (matched by $720,000 in Medicaid funds) to initiate family planning services in six Community Service Offices (CSOs). CSOs are Washington's version of what in many states are known simply as welfare offices; they house cash aid, Medicaid, and food stamps programs. Because all Medicaid recipients visited the CSOs at some point, they were considered a good base for the project. By providing information about the effects of substance abuse on pregnancy, the project addressed Representative Sommers' primary concern.

"The important thing is that we were able to jump on the opportunity when it came," says Claudia Lewis, the Medicaid agency staff member most involved in the initial family planning efforts. "We already had ideas from the community meetings, and we had supportive management that was willing to look at doing business in new and creative ways." Indeed, one of the unusual aspects of Washington's initiative, right from the start, was the role played by Lewis and by the Medicaid agency in actively coordinating with community-level providers and the Department of Health to increase access to services and make the system work more smoothly.

The six pilot sites developed their family planning initiatives locally. In Spokane, the CSO contracted with a family planning agency to hire a teen advocate and counselor, who was based in the CSO and whose job it was to interact with teens. In Kelso, the CSO hired a former recipient to do outreach. She contacted everyone in a particular zip code, talking about family planning and dispensing safer sex kits; she also held group meetings in clients' homes.

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When the Washington legislature changed the state's welfare system in 1994, Representative Sommers spearheaded a drive to expand the pilot project so that all CSOs in the state would be involved in family planning activities. "We should push family planning whenever there's an opportunity," she says. "I strongly believe in independence for women. They're not going to be able to stand on their own two feet if they keep getting pregnant. Family planning is the most important health decision for women. We need to provide this help to them."

The law required that the Department of Social and Health Services (DSHS, the umbrella agency for both welfare and Medicaid) "shall offer or contract for family planning information and assistance, including alternatives to abortion, and any other available locally based teen pregnancy prevention programs, to prospective and current recipients of aid to families with dependent children."[95] It also required DSHS to train financial workers and social work staff to provide family planning information and assistance, in addition to referring clients to job opportunities and training programs and providing other social services.

When it financed the initiative, the legislature fleshed it out by providing funding for CSOs to contract with family planning agencies for itinerant nurses, allocating family planning positions in the CSOs, and creating a media campaign.

In July 1997, Washington implemented its revised welfare program, WorkFirst, following federal welfare legislation. At this time, the Department of Social and Health Services adopted an explicit goal of zero additional births to women receiving welfare and required that welfare case managers refer all clients for voluntary family planning information or services. Mike Masten, head of the welfare program, was an early supporter of locating family planning services in CSOs. When work requirements and time limits were instituted, he saw another reason to integrate family planning services into welfare. He says: "It's a natural to connect family planning to welfare reform. We're not making a judgement about people's choices, [but] we want people to understand that being pregnant and having a newborn will impede progress toward self-sufficiency and make their lives more difficult."

ELEMENTS OF THE INITIATIVE

Nancy's Story

"Nancy" first visited the nurse practitioner at her local welfare office because she was confused about her medical coverage for birth control. She had "family planning coupons" provided by the state to low income women at no cost to them for ten months after a pregnancy, but the pharmacy had mistakenly told her the coupons didn't cover condoms.

As Nancy described her situation, the nurse, Jean Fletcher, realized that the 21-year-old had almost no knowledge of birth control methods. Her family had never raised the subject, and although she had been taught sex education in school, she didn't remember much. She used condoms exclusively, and she and her husband had already had one unintended pregnancy.

During their hour-long conversation, Fletcher dispelled many of Nancy's misperceptions about birth control methods, such as her belief that Depo Provera was injected into the spine. Fletcher provided her with condoms and a pack of birth control pills to start after her next menstrual period or to keep as emergency contraception, and she referred her to a clinic for continuing reproductive care. Nancy was still not sure what method she wanted to use; she was considering using spermicidal foam.

Unbeknownst to both of them, Nancy was pregnant when she visited Fletcher. Nine months later, after giving birth to her second child, Nancy received a letter from Fletcher inviting her to discuss birth control. She visited Fletcher at the welfare office a second time. Now, Nancy decided she wanted to use birth control pills. Fletcher again provided her with condoms and a starter pack of pills and referred her to another provider. A few weeks later, the two women saw each other on the street, and Nancy confirmed that she was using birth control pills.

"We got to her through continuing education," Fletcher says. "She had a doctor for both pregnancies, but they didn't talk to her about birth control. Most providers just don't have the time to really talk with women. We do." In two lengthy counseling sessions, Nancy was able to express her doubts and fears about birth control methods and eventually decide on a method that would work for her.

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Itinerant nurses

The Medicaid agency contracts for itinerant nurses to be based out of CSOs. The nurses, who are from local Title X family planning agencies, work varying hours depending on the size of the CSO. Nurse practitioners can provide family planning counseling and education, pregnancy tests, over-the-counter birth control and prescription birth control that does not require a pelvic exam, such as three months of birth control pills, Depo-Provera, and emergency contraception. They can refer clients to other providers for additional health services, and they can make appointments for clients for full clinical services at the family planning agency. Registered nurses must get a physician's approval to administer prescription birth control.

There is a shortage of nurse practitioners and registered nurses in Washington, and not all CSOs have been able to fill the positions. For example, one family planning agency is working with seven different CSOs and can't find nurses to cover them all. According to a 1999 survey, three-quarters of all CSOs have a family planning nurse on site at least once a week. Nearly half have prescription birth control available on site, mostly emergency contraception.[96]

> Three-quarters of all CSOs have a family planning nurse on site at least once a week. Nearly half have prescription birth control available on site.

CSO family planning workers

In addition to contracting with itinerant nurses, CSOs house their own family planning workers. However, their tasks are mostly information or referral, not medical. Each CSO structures the job differently. Some CSOs have set it up so that the family planning worker fills in when the nurses are not on site.[97] Others have designated their family planning worker as a liaison between the nurse and the client. Others have viewed family planning workers as outreach and education positions and have sent them out into the community. In many CSOs, the First Steps social worker who does referral for pregnant clients has also taken on the responsibilities of the CSO family planning worker.

When it created the initiative, the state funded 42 family planning positions to be spread throughout the state's 65 CSOs. Since then, the number has shrunk to 31. Nearly three-quarters of all CSOs have a staff member spending 20 hours a week or more on family planning[98]; it is unclear, however, how much of this time is spent on pregnant clients in the First Steps program and how much is spent on other clients.

Co-located clinics

Eight CSOs have provided space in their buildings for family planning clinics. These clinics are open two to three days per week, and they offer a full range of family planning services. The clinics are open to the public at large; clients without Medicaid or state-funded coverage pay on a sliding fee scale. As with the itinerant nurses, the extent to which the clinics' services are coordinated with the welfare agency varies from site to site.

Family planning referrals

The welfare program requires case managers to refer all clients to a family planning worker or nurse for voluntary services. Decisions about how referrals should be made are generally left up to individual CSOs. For pregnant clients, however, the First Steps program provides a uniform statewide referral process. For these clients, case managers check a box pertaining to First Steps on their intake screens, making a referral to the First Steps worker. Based on an assessment, the First Steps worker then fills out a written family planning referral form that is submitted to the CSO nurse or another provider.

Family planning is not a required element of welfare recipients' individual responsibility plans (IRP), although Mike Masten, the head of the welfare program, says that the ideal IRP would include an agreement to follow through on a family planning referral. Failure to do so, however, would not be sanctionable: "We don't think we have a moral authority to sanction for family planning referrals. We need to make the case that it is about helping people access services that they might not know about." Rather than punishing them for not taking advantage of the services, he says the program "ought to make it easier for them."

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Staff Training

When the CSO family planning initiative was created, all CSO staff, from clerical workers to welfare case managers and social workers, were given a training in family planning basics and in the initiative's elements. Since then, it has been up to individual CSOs to schedule full-staff trainings.

The Medicaid agency does yearly trainings for CSO family planning workers, their supervisors, the itinerant nurses, and the administrators of the family planning agencies. Quarterly meetings are also held on a regional basis. At both of these, participants share information and brainstorm about ways to improve the program and reach more clients.

In addition, the Medicaid agency published a handbook in 1997 that describes the initiative, suggests activities for nurses and family planning workers, and advises how to assess and work with clients. This handbook is now on site at over 90% of CSOs and other states have been provided copies upon request.

Information Dissemination

In 1994, the legislature also created a family planning media campaign targeted to Medicaid clients. The campaign's primary message on these materials is "Birth control methods work. Let's talk. One is right for you." The state produces materials such as condom key chains, flyers, pens, and plastic bags that reinforce this message. It also produces posters for use in transit

advertising and to hang in CSOs. All materials list a toll-free number that describes family planning services and gives information about family planning providers statewide.

There are also two items that tie family planning directly to the welfare program. The first is a flyer that describes the program including support services, work requirements, and the availability of free family planning services. The second is a poster showing half of a woman or man's face emerging over a barbed-wire fence, its caption: "Welfare is for hard times, pregnancy makes it harder. Let's talk about birth control."

LOCAL IMPLEMENTATION

Bellingham

Bellingham is a small city in northwestern Washington; nearly half the births to women in the county are paid for by Medicaid.[97] The Bellingham CSO is large, with a total of 8,800 cases, including food stamps, Medicaid, and cash aid. There are slightly more than 1,000 TANF cases. A family planning nurse works on site for 20 hours per week.

The family planning program at the Bellingham Community Service Office is singled out by state officials as one of the most successful in Washington. They point to the good relationship between the CSO and the family planning contract agency, to the smooth integration of the nurse into the CSO, and to the support shown to the program by the administrator of the CSO.

But when the program was initiated in Bellingham in 1994, it was not an immediate success. "Initially, we said 'what's that?' when they asked us to partner with the CSO," recalls Linda McCarthy, assistant director of Mt. Baker Planned Parenthood, the contract agency. "One of the first jobs was to do a training for all of the CSO workers. We had two wonderful trainers. It was a disaster!" The case managers, who up until then had focused exclusively on financial eligibility, were uncomfortable with the idea of mentioning family planning and didn't know how to integrate what they were learning into their jobs. In addition, the cultures of the CSO and the family planning agency were very different.

Sylvia Ketchley, the itinerant nurse practitioner who has been at Bellingham since the beginning, also says it was rough at first. "When I first came, people thought we were going to get bombed. They didn't want condoms anywhere. They were dead scared." Ketchley was placed in an office at the back of the CSO, but quickly set herself up at a table in the lobby so she could have direct access to potential clients.

"When I first came, people thought we were going to get bombed. They didn't want condoms anywhere. They were dead scared."

The CSO began warming up to family planning with the arrival of a new administrator, Marijo Olson. Olson is a strong proponent of family planning; in her previous CSO she had been photographed by the local paper filling a rest room condom dispenser. Olson gave Ketchley a nurse's office off the lobby of the CSO, conferred regularly with Planned Parenthood, and impressed upon her staff the importance of family planning.

Olson considers family planning to be a job responsibility for all case managers and social workers dealing with the TANF population, but she also believes that CSO staff working with clients in other programs should be well versed in the subject. "We really feel that family planning has to be a CSO-wide thing," she says. "So when we do a family planning training, everyone's got to do it, everyone has to be comfortable with it. When they get off TANF, in many cases they'll still be on food stamps and Medicaid."

CSO staff working with clients in other programs should be well versed in the subject. . . "When [clients] get off TANF, in many cases they'll still be on food stamps and Medicaid."

In order to make everyone in the CSO comfortable with the topic, Olson has instituted a policy of yearly all-staff trainings relating to family planning. In 1999, this training was intended to integrate family planning into a uniform message about self-sufficiency so that welfare staff would better understand how family planning connected with other elements of their work and get ideas for raising the topic with clients. Positioning self-sufficiency as the core goal of the welfare system, the training provided workers with messages linking employment, family planning, education, transportation, health, and child care to self-sufficiency.

The training's messages reflect the shift in Washington from a welfare system focused on financial eligibility to one in which workers are expected to address the social service needs of clients. Bellingham case manager Roberta North explains: "When we were just in eligibility years ago [family planning] wouldn't have fit in, but the way the program is now, we take the client as a whole, and we look at all the barriers to self-sufficiency. Family planning is a large portion of the pie." Now, North raises family planning with her clients during intake interviews and orientation by making sure they know what services are covered by Medicaid; she then mentions how an unplanned pregnancy can be a barrier to self-sufficiency and tells clients there is a family planning nurse in the office if they want more information or services. "We'd be in the dark without the training," she says.

The training was also designed to make sure that when case managers and others discuss family planning with clients, they do so in a supportive way. "Our concept is you need to use family planning to get control of your life and protect your health until you're ready for a planned pregnancy," says Planned Parenthood's McCarthy. She believes the welfare program's goal of zero births to welfare clients is a negative message: "Zero *unintended* births is a better message. Poor people have the right to have kids."

While Olson, the CSO administrator, agrees on the importance of motivating clients through supportive messages, she sees the situation slightly differently. "We try to make it a reasonable message, but the welfare reform message is a harsh message, there's no kidding about that. What we often have to say is, 'OK you started out with 60 months and you've got 24 months left, so what are you going to do to get off assistance in the next 24 months?' That is harsh, that sounds harsh, but right now that's the drill. How that fits into family planning is, 'having a baby during that time pretty well kills the rest of your time, so now are you and the new member of your family going to be cut off? What are you going to do?'"

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Olson also says that pressure from the state to reduce caseload size is an incentive for case managers to talk about family planning. "Anyone who gets pregnant you still have on your caseload as one of your numbers, and that detracts from your success in marshaling people through that process [of moving into the workforce]," she explains.

> "[T]he welfare reform message is a harsh message . . . How that fits into family planning is, 'having a baby . . . pretty well kills the rest of your time . . . What are you going to do?'

Despite the training, Olson's support of family planning, and the state's referral requirement, few case managers actually refer clients to Ketchley, the nurse. "The idea was that the financial workers would send any client that they felt needed family planning to me," she says. "Unless they're pregnant, that hasn't instigated a lot of people. Had I been waiting for the financial workers, I'd probably see three people a week." The referral requirement is not institutionalized: there is no established referral mechanism locally or statewide, there is no definition of what constitutes a referral, there is no tracking of referrals, and it is not a factor in assessing case managers' job performance. As a result, whether case managers mention family planning and make referrals is largely based on their own comfort level and initiative. Some may mention the services but not actively refer to Ketchley; for others, family planning has still not become part of their intake routine.

There is an established system that refers pregnant clients to Ketchley through the First Steps program. But the vast majority of her clients are walk-ins: people who have heard about the services at the CSO through word of mouth or at a community agency. Many of these clients are not already receiving benefits, according to Ketchley. They come in for pregnancy tests, and once their pregnancy is confirmed, they apply for TANF or Medicaid, depending on their income level. Most of these walk-in clients do not have doctors or regular medical care, Ketchley says. She refers them to the area's low-cost clinics for other medical needs. She also follows up with the pregnant clients by calling them three months after their delivery date, to make sure they are receiving post-pregnancy coverage for family planning and to discuss birth control with them.[100]

Working at the CSO three days a week, Ketchley sees a total of about 700 clients per year. Approximately one-quarter of her clients, who are for the most part poor and white, have an unplanned pregnancy when they first visit her. The overwhelming majority of these clients have never before accessed family planning services from the local Planned Parenthood clinic.[101] Yet nearly one-third of the clients Ketchley sees at the CSO later become clients at the clinic. This suggests that locating family planning services in the CSO provides an effective outreach to a different population.

At the CSO, Ketchley provides a number of services. In addition to administering a pregnancy test to virtually every client she sees, she also provides every client with condoms and spermicide. For a subset of these clients, she dispenses "starter" packs of birth control pills, emergency contraception, and other methods that do not require a pelvic exam.

Ketchley also provides clients with counseling and education. She finds that clients often have a mistaken understanding of how methods work, or they are undecided about which one to use. She says that she has much more time to talk with clients at the CSO than she or anyone has at the family planning clinic. "We see youngsters who come in with a million questions. School counselors have brought their students from school." She also does presentations on birth control and the CSO family planning program for TANF clients in work training classes.

Ketchley believes it is a critical part of her job to do counseling and advise clients that over-the-counter birth control is covered by Medicaid and the state family-planning expansion.[102] "Clients are given so much information when they come to the CSO—it's a maze. I know the financial people tell them their medical coupons [given to clients of both Medicaid and the state-funded family planning expansion] cover birth control or give them things to read. Then I see them at Planned Parenthood and ask them, 'do you know your medical coupons cover that?' and they say 'no.' The message needs to be reinforced."

"Clients are given so much information when they come to the CSO—it's a maze. I know the financial people tell them their medical coupons cover birth control . . . Then I see them . . . and ask . . . 'Do you know your medical coupons cover that?' and they say 'no.' The message needs to be reinforced."

The CSO, Planned Parenthood, and Ketchley would like to expand her hours at the CSO to a full 40 per week. This would give her time to visit clients at home and to do more outreach. Ketchley would particularly like to find a way to reach more men through the program. She would also like a more direct liaison in the CSO. While Olson does not want to give one particular CSO staff member the job of family planning worker because she wants all the staff to be equally invested in the program, Ketchley finds the high job mobility among CSO staff to be problematic because her contacts change frequently. A designated family planning worker would give her a more solid link to the CSO staff and help her learn about all of the services that clients can access through the CSO.

Overall, both the CSO and Planned Parenthood feel the Bellingham family planning program is a success. Although the referrals from welfare case managers are not as frequent as Olson and Ketchley would like, the free pregnancy tests have proven to be a valuable way of providing counseling and services to walk-in clients. All agree that Ketchley's warm and outgoing personality has put both clients and CSO workers at ease, helping to make family planning an integral part of the CSO.

Mount Vernon

Mount Vernon is located in northwestern Washington's Skagit County, where over half of the births are paid for by Medicaid.[103] The CSO has 900 TANF cases. It has a co-located family planning clinic, a CSO-based itinerant nurse, and a social worker who spends a quarter of her time working on family planning. The contract family planning agency for Mount Vernon, as for Bellingham, is Mt. Baker Planned Parenthood.

The clinic at Mount Vernon is in the same building as the CSO, but it does not share a common front door. Other agencies in the building provide services to children, the elderly, and people with disabilities. The Mount Vernon clinic offers a full range of family planning services. Patients are usually seen by appointment, although there is some flexibility for walk-ins. Since opening in February 1998, the clinic has served 1,800 clients annually. It is open three days per week.

In the CSO, there is an office for the itinerant family planning nurse. The nurse is scheduled to be there 20 hours per week. The nurse's position pre-dated the clinic and, when the clinic opened, the idea was that the nurse would cover referrals and walk-ins on the clinic's off days, as well as continue to provide information and counseling. However, the system has evolved quite differently in practice.

In fact, the CSO has largely kept its family planning program within the CSO itself, and has established few direct links with the clinic. There is no mechanism in the CSO for referring clients directly to the clinic. Rather, case managers refer interested clients initially to the family planning worker, who explains to them the value of family planning. If the clients want more detailed information, a pregnancy test, or prescription birth control, the family planning worker then refers them to the nurse in the CSO. If clients tell their case managers that they think they might be pregnant, or if the family planning worker is out of the office, the case managers refer them directly to the nurse. If clients need clinical services beyond what the nurse provides, the nurse will refer them to the clinic.

For a couple of months in 1999, the CSO did refer clients seeking pregnancy tests directly to the clinic, because the nurse's position in the CSO was vacant. But staff at both the clinic and the CSO found this to be complicated. They say it is more difficult to keep track of the nurses' hours for billing to the CSO, it might disrupt the appointment schedule at the clinic, and it creates confusion for clients because they can receive services for free if they are referred by the CSO but have to pay on a sliding scale otherwise. They say that the benefit of having a co-located clinic is enhanced access: clients can schedule a family planning appointment at the same time that they are coming to see their case manager; or clients who receive positive pregnancy tests at the clinic can fill out Medicaid forms at the clinic and walk them directly over to the CSO.

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Within the CSO, the family planning program has not operated very smoothly. This is largely attributable to the fact that Planned Parenthood has had trouble keeping nurses in the job on a long-term basis. Nurse practitioners and nurses are in high demand in the state, and few are interested in part-time positions. The lack of consistent nurse staffing inhibits referrals from case managers, according to Steve Hayes, the head of social services at the CSO. "We've had someone in and out, so the case managers don't refer much," he says. "Case managers are real busy people. If a couple times they go back there to try to get someone to talk to them and they're not there, they don't end up taking the time. They may make a [written] referral, but that

might be too late. I think being able to see someone right then is one of the most important things; to catch them while their interest is there."

The location of the nurse's office and her role vis-à-vis the family planning worker may have created additional obstacles to fully incorporated family planning services into this CSO. Unlike in Bellingham, where the nurse's office is directly accessible from the lobby, the nurse's office in Mount Vernon is at the back of the CSO; clients who ask for services at the front desk must be escorted back there by a CSO worker. Hayes argues that clients like to have the confidentiality of an office that is not directly off the lobby, where someone they know might see them enter. However, this location and the fact that most referrals are made to the family planning worker instead of the nurse means that the nurse in Mount Vernon sees many fewer clients than Ketchley does in Bellingham. According to Linda McCarthy and others at the family planning agency, nurses at the Mount Vernon CSO might see only one client a day and perform pregnancy tests almost exclusively. McCarthy says that this has led nurses to feel underutilized and isolated, a problem that also occurs elsewhere in the state and makes it even more difficult to keep nurses in the position.

Hayes says that staff supervision is another complicating factor. Because he is the social work supervisor and the family planning position falls into his department, he is in charge of the family planning program at the CSO. However, he is not in charge of the nurse. "I feel responsible for it, but I don't have control. It's been frustrating. I'd rather have the CSO hire them and have me supervise them." Hayes is not in charge of the case managers either. They report to an economic services manager. As a result, he can encourage them to make referrals, but he can do little else. He does have the authority to conduct staff trainings on family planning, but he has not done this since the implementation of the welfare program.

Christine Plummer, the family planning worker, believes that additional training would benefit the staff. She says that there are a few case managers who do consistently refer clients to her. However, she says that referrals are triggered by families with large numbers of children and are driven by a stereotypical reaction to families receiving welfare. For one client, "the case manager said to me: 'When I informed them their refugee status was going to end soon, they immediately went out and she got pregnant.' I felt that was a heavy-handed attitude. However, it did get the woman to me early in her pregnancy so I could make appropriate referrals for her medical care." She attributes this attitude to the fact that the case manager position is still very new, most of them have a financial background, and they are still learning the difference between advising clients and trying to make them do what the CSO thinks they should do. She says she has seen real strides in terms of attitude change over time.

Case managers are still learning the difference between advising clients and trying to make them do what the CSO thinks they should do.

Hayes says that when the CSO had a nurse in the position consistently it worked well. He would ultimately like to have the nurse at the CSO full time, so as to create more consistency for case managers and clients. Planned Parenthood would like the clinic to become more closely linked to the CSO and for the nurse to take on a more active role. Plummer, who calls the program a

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reserved success, would also like to see it become more dynamic. She would like to spend more time at women's health fairs and employment fairs and explore other avenues for community outreach.

Forks

Forks is a remote, rural community on Washington's Olympic Peninsula. Sixty percent of births in the county are paid for by Medicaid[104]. The Forks CSO is small: it has a total of 1,350 cases; of these 310 are TANF cases. It has no social workers on site and shares one First Steps worker with a larger CSO more than 50 miles away. A family planning nurse practitioner is based out of the CSO approximately 12 hours per week.

The small size of Forks and its CSO, as well as the economic conditions of the community, have been important influences on the development of the family planning program there. The head of the CSO, Andy Pascua, was a social worker before becoming an administrator. He says that, unlike in larger cities, the CSO clients and staff in Forks are all part of the same community. In addition, the area has gone through a significant economic upheaval in the past decade, due to loss of jobs in the timber industry. Pascua says those clients who were able and willing to take advantage of job retraining have done so and moved away from the community. Those who are left on the welfare rolls either have deep roots in the community and are unwilling or unable to move away, or are suffering from mental disorders, substance abuse, or other significant problems. Pascua says that what people speak of as "the next stage of welfare reform—we're already there [in terms of who's left on the rolls]. We don't have jobs readily available. People are getting menial jobs, but do we have resources to move them on to other jobs and careers? I would say no."

As a result, he is very worried about what will happen when clients are forced off the rolls by time limits, and he believes it is essential for the CSO to provide as much support and social service help to clients as it can. He sees the family planning program as a great benefit: it has brought a nurse into the CSO who can train staff and answer their questions, serve as a community liaison, provide services that are in some cases otherwise unavailable in Forks, and focus on educating teens so as to avoid future unintended pregnancies in the community.

Jean Fletcher, the nurse practitioner from Clallam County Family Planning, is well-integrated into the CSO. In fact, she started working there as a CSO-employed family planning worker, before the site was given permission to contract for a nurse. When the program was first developed, she talked with clients as well as the area's schools, Native American tribes, and health providers, telling them about the program and asking them what type of services they would like her to provide.

The nurse also asked case managers how they envisioned doing referrals, and what would help them to do them consistently. Based on their response, she developed a family planning questionnaire for clients to complete and return to their case managers during their intake interviews.

Fletcher also asked case managers how they envisioned doing referrals, and what would help them to do them consistently. Based on their response, she developed a family planning questionnaire for clients

to complete and return to their case managers during their intake interviews. On it, clients can respond that they are interested in learning more about family planning choices or discussing their current method of birth control, or they can decline additional information by saying they have a current method of birth control and are pleased with it. The questionnaire also asks the names and ages of children in the household over ten years old, so that Fletcher can ask parents whether they want information for their children or advice on how to speak to their children about reproductive health matters.

In addition to the questionnaire, some case managers directly discuss family planning with their clients. Terri Ross explains her motivation: "They have to be off in five years. I don't want to feel like I've failed them. I want to feel I've done everything I can to help them become self-sufficient in that time." Ross brings up family planning in the context of unintended pregnancy and says, "I discuss it with every client unless they tell me they've had their tubes tied."

During the hours that case managers are doing intake interviews, Fletcher makes sure to be in the CSO and available to see clients. She estimates that she sees one or two clients these days. She also telephones and writes to those who indicate that they want information but do not have time to see her immediately. After seeing clients, she writes follow-up letters reminding them that Medicaid covers all forms of contraception and that she is available for further services. She also contacts First Steps clients to discuss family planning following birth or termination of their pregnancies.

Fletcher provides basic information about family planning, unintended pregnancy, and the CSO family planning program to welfare recipients in job training classes. She also teaches reproductive health education classes at local schools and talks to clients in court-mandated parenting classes about how to address sexual issues with their children. She and Pascua team up to teach at three tribal schools. Fletcher says it is wonderful to have Pascua join her, because he is Native American while she is white and the students can relate better to him. Fletcher has also been invited by clients to visit their homes to discuss family planning with their teenagers. She concedes that she has become the primary reproductive health educator in Forks.

The fact that the community is so small means that Fletcher knows other providers personally and can follow up easily with them after making referrals. Fletcher says that it also means that clients often worry about privacy at the community family planning clinic, and they are able to see her with a greater degree of confidentiality because they can make it seem like a regular visit to the CSO. Also, when clients have a problem relating to services or their Medicaid, they can tell her: one client complained that the local pharmacy was not allowing her to buy contraceptive foam with Medicaid, and Fletcher quickly called the pharmacy to inform them that over-the-counter contraceptives are covered. Finally, Fletcher makes an effort to discuss emergency contraception and provide it to clients, most of whom have never heard of it before.

Fletcher and Pascua feel the Forks family planning program is a success. A successful program, Fletcher says, must have both an education/outreach component and a clinical component. She also believes the program doesn't need to be centered in the CSO, particularly as the welfare caseload declines. "We need to ask 'where should we go with family planning now?' Maybe we should be at the family support center, the food bank, and other points of contact."

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CONCLUSION

Washington's CSO-based family planning initiative has come a long way since establishing its first pilot sites in 1992. A statewide infrastructure now enables family planning information, education, and services to be provided in most CSOs, and sites like Bellingham are held out as models for a successful program.

While they are proud of their accomplishment, those involved in the initiative know that work remains to be done to overcome implementation challenges. In August 1999, the state published a qualitative study of the initiative, based on interviews with staff at five CSOs, that documents implementation challenges and provides strategies for addressing them. The report also identifies what staff believe are critical factors for program success, in particular: the skills, personality and presence of family planning staff; and accessibility of family planning services, education, and information. Finally, the report highlights staff recommendations for the future, including: prioritizing family planning services at the local CSO and state levels; targeting a broader population; hiring more family planning staff; and developing outcome measures.[105] The state plans to use the report to further strengthen the initiative statewide. In addition, the yearly statewide trainings and quarterly regional trainings for family planning staff and nurses are valuable arenas for brainstorming new ideas.

Washington is also hoping to expand the program by enabling more clients to take advantage of it. In 1999, the state applied for a Medicaid waiver that would increase coverage for family planning to 200% of the federal poverty level and cover all women and men, not only pregnant and post-pregnant women. State officials believe that the CSO-based linkages will be a valuable mechanism for providing these newly-eligible clients access to family planning education and services.

ENDNOTES

[1] The 1996 welfare law based state TANF allocations on the caseload levels of the early 1990s. Since then caseloads have been declining and states are reporting unspent TANF funds. "TANF Program Expenditures in FY 1999 Through the Second Quarter" available at http://www.acf.dhhs.gov/programs/ofs/data/q299/index.html

[2] While these interfaces put welfare policy into the reproductive health arena, the connection to family planning can be tenuous. For example, in New Jersey, the first state with a family cap, the state took no special action when the provision was initially implemented to improve family planning access or promote pregnancy prevention for those welfare recipients subject to the rule. *Excluded Children: Family Cap in a New Era*, Jodie Levin-Epstein, February 1999. Available at: http://www.clasp.org.

[3] By definition, families who receive cash assistance are among the poorest families; when a family needs subsistence assistance it is vulnerable and might accept requirements it otherwise would reject. An illustration of how welfare might link family planning in a potentially coercive manner occurred in Mississippi, where a 1992 bill for redesigning the welfare system initially called for welfare recipients with four or more children to undergo mandatory Norplant implants; the provision was later dropped. *Is There a Link Between Welfare Reform and Teen Pregnancy?* Richard P. Nathan, Paola Gentry, and Catherine Lawrence, The Nelson A. Rockefeller Institute of Government, Rockefeller Reports, April 2, 1999.

[4] *The 'Illegitimacy Bonus' and State Efforts to Reduce Out-of-Wedlock Births*, Patricia Donovan, Family Planning Perspectives, (Vol. 31, No.2, March/April 1999) and *State Teen Pregnancy Prevention and Abstinence Education Efforts*, John Sciamanna, American Public Human Services Association, (July 1999). The former reports 34 states and the latter 46 states that have taken some steps to address out-of-wedlock births.

[5] *Is There a Link Between Welfare Reform and Teen Pregnancy?* Richard P. Nathan, Paola Gentry, and Catherine Lawrence, The Nelson A. Rockefeller Institute of Government, Rockefeller Reports, April 2, 1999.

[6] *Family Planning Referral: States Train Welfare Staff*, CLASP UPDATE, July 31, 1999 and *The 'Illegitimacy Bonus' and State Efforts to Reduce Out-of-Wedlock Births*, Patricia Donovan, Family Planning Perspectives, (Vol 31, No.2, March/April 1999).

[7] Enhancing the ability to plan a pregnancy applies to each pregnancy, not just the first. Among teens, second or higher order births account for 20% of all births. *More Than One: Teen Mothers and Subsequent Childbearing* Renni Greer, December 1998. Available at http://www.clasp.org.

[8] 42 U.S.C. 602 (a)(15). The 1967 amendment and subsequent related changes were made to the part of the AFDC law that defined the requirements of state AFDC plans. It sought family planning services that would be "provided promptly" to all those in the household "including minors who can be considered to be sexually active" who voluntarily requested them. To ensure participation was voluntary, the provision explicitly stated that family planning services "shall not be a prerequisite to eligibility...."

[9] State AFDC plans did not delineate how states implemented 42 U.S.C. 602(a)(15) and no separate Administration for Children and Families' analysis collected information from the states on this topic, according to ACF (author's correspondence with ACF, 1999). However, the need for effective links was identified in at least one state. In 1992, the Nevada welfare department surveyed AFDC recipients and discovered that 10% of the respondents were pregnant. Of that group, 70% had not received family planning counseling, but nearly 50% said they would have utilized such services had they been offered. *Nevada State Welfare Department. AFDC Client Survey* (August-September 1992).

[10] *Is There a Link Between Welfare Reform and Teen Pregnancy?* Richard P. Nathan, Paola Gentry, and Catherine Lawrence, The Nelson A. Rockefeller Institute of Government, Rockefeller Reports, April 2, 1999.

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[1] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-93, includes TANF as Title I. 42 U.S.C. 601 et.seq.

[2] John Sciamanna, Senior Policy Associate, American Public Human Services Association, conversation with author.

[3] PRWORA, Title IX, Sec. 912 "Abstinence Education." 42 U.S.C. 710.

[4] Title I of PRWORA explicitly authorizes spending on "pre-pregnancy" family planning services. 42 U.S.C. 698(a)(6).

[5] *Teen Parent Provisions in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.* Center for Law and Social Policy, November 1996.

[6] HHS calculates the proportionate change in each state's ratio of out-of-wedlock births to total births. The five states with the greatest decrease in this ratio are potentially eligible for the bonus. HHS then calculates the abortion rates for these states. If a state's abortion rate is lower than its 1995 abortion rate, the state will receive its share of the bonus. 45 C.F.R. 283.3, 283.5.

[7] In addition to Medicaid, the federal sources include CHIP, the State Child Health Insurance Program; Title X of Public Health Service Act; Title V, the Maternal and Child Health Services Block Grant; and Title XX, the Social Services Block Grant. *Family Planning Through Four Federal-State Programs, FY 1997*, Gold, R.B. & Sonfield, A., Family Planning Perspectives, 31(4) July/August 1999; *Block Grants are Key Sources of Support for Family Planning*, Gold, R.B. & Sonfield, A., The Guttmacher Report on Public Policy, August 1999; *State CHIP Programs Up and Running, But Enrollment Lagging*, The Guttmacher Report on Public Policy, October 1999; *Issues in Brief: The U.S. Family Planning Program Faces Challenges and Changes*, available at http://www.agi-usa.org/pubs/ib3.html.

[8] *Contraception Counts: State-by-State Information*, Alan Guttmacher Institute web site, http://www.agi-usa.org/pub/ib22html, 1999.

[9] It would be factually inaccurate to read this data and conclude that welfare families are large. Welfare families average two recipient children; two of five welfare families have only one child and only one in ten families have more than three children. *Temporary Assistance for Needy Families (TANF) Program Second Annual Report to Congress*, Department of Health and Human Services, August 1999.

[10] *Unintended Pregnancy in the United States*, Stanley Henshaw, Alan Guttmacher Institute web site, http://www.agi-usa.org/pubs/journals/3002498.htm., 1998. The percent of unintended pregnancies that ended in abortion in 1994 was 49% for those below 100% of poverty and 47.9% for those below 200% of poverty. Wealthier women, those above 200% of poverty had the highest incidence of abortion - 61.5%.

[11] *Unintended Pregnancy in the United States*, Stanley Henshaw, Alan Guttmacher Institute web site, http://www.agi-usa.org/pubs/journals/3002498.htm., 1998.

[12] *Contraception Counts: State-by-State Information*, Alan Guttmacher Institute web site, http://www.agi-usa.org/pub/ib22html, 1999.

[13] Unemployment insurance is generally unavailable to assist these families between jobs. Most states have unemployment insurance eligibility requirements that disqualify workers who leave their jobs to deal with family responsibilities, such as those arising when child care fall through. *Women, Low-Wage Workers and the Unemployment Compensation System: State Legislative Models for Change*, National Employment Law Project, October 1997, Revised Edition.

[14] Only part of the employment increase is attributable to the 1996 welfare law and its emphasis on "work first", placing welfare recipients in a job before training or education. The trend began before the 1996 law was enacted.

For example, among AFDC recipients, of those in the program in the previous year nearly 20% were employed in 1992; by 1994 that number had grown to 23%. Similarly, for all single mothers under 200% of poverty with children under the age of six, the percent employed in 1992 was 34.8% and that grew to 39.4% in 1994. *Temporary Assistance for Needy Families (TANF) Program, Second Annual Report to Congress*, U.S. Department of Health and Human Services, August 1999, table: "Employment Status of Single Mothers and Previous Year AFDC Recipients" available at http://www.acf.dhhs.gov/programs/opre/tanfreports/tan19995.pdf.

[25] This study was conducted in the state of Florida. Twenty-six percent of the respondents reported that they knew of a better job they could get if they had better child care and 22% reported they had missed work in the last month because of a child care problem. Thirty-three percent indicated that child care problems had led to a change in work hours, while 22% reported such problems led to a change in jobs and 17% reported that child care problems led to a new line of work. In sum, 51% answered "Yes" to one or more of these questions. *Child Care After Leaving Welfare: Early Evidence form State Studies*, Rachel Schumacher and Mark Greenberg, October 1999 available at (http://www.clasp.org) for an overview of child care's impact on welfare receipt. *Access to Child Care for Low-income Working Families*, a report by HHS (available at http://www.acf.dhhs.gov/news/ccreport.htm) which concludes that: "Welfare reform makes it likely that the demand for quality child care will be even greater in the future. Unfortunately, the cost of child care is often beyond the means of low and moderate-income working families, including those who have never been on welfare."

[26] State welfare policy establishes the age of child which triggers a work exemption for the parent. State Policy Documentation Project, unpublished preliminary TANF findings. SPDP is a joint project of CLASP and the Center on Budget and Policy Priorities. Published material is available on the web site, http://www.spdp.org.

[27] U.C. Data, at the University of California Berkeley is conducting the evaluation. The impact report will include information on family planning which is not addressed in the process report. Cal-Learn reports are available at http://ucdata.berkeley.edu/new_web/calearnintro.html.

[28] Information provided by Jan Treat, Chief, Clinical Services Section, the Office of Family Planning, California Department of Health Services. An evaluation of the demonstration project was published in 1998, First Stop Program Evaluation Report, University of California San Francisco Family Planning Institute, June 1998. There will be no subsequent final evaluation.

[29] Family PACT may also affect the welfare system since providing family planning services to low income clients may help them avoid a pregnancy that could push them further into poverty and onto the cash aid rolls.

[30] The term abstinence-based education is "shorthand" for curricula that encourage abstinence but also provide information about contraceptives for those who are sexually active. In contrast, the term abstinence-unless-married education refers to curricula that teach abstinence as the only option and provide no information about contraception.

[31] *Take Charge, Washington State's Family Planning Services Section 1115 Waiver Project*, Medical Assistance Administration, Washington Department of Social and Health Services. December 1998, p. 6. Standard Medicaid policy provides two months of post pregnancy family planning services; the 10 months of state-funded post pregnancy services allows individuals to receive a total of 12 months.

[32] House Bill 2798, Part 1, Section 3, State of Washington, 53rd Legislature, 1994 Regular Session; *Revised Code of Washington*, 74.12.410.

[33] The media campaign is funded 50% by Medicaid funds and 50% by state funds for the most part. Its bus posters are paid for entirely by state funds.

[34] *Family Planning in Washington State Community Services Offices: Challenges and Strategies*, Janet Campbell et al, Research and Data Analysis, Washington Department of Social and Health Services, August 1999. This report contains ideas and activities for overcoming barriers such as community opposition, and client and staff discomfort with discussions of family planning. A number of the factors it identifies as critical to program success—such as

accessibility of services, program flexibility, and respect for clients as individuals—are also addressed here in *Making the Link*.

[35] *Contraception Counts: Washington Information*. Alan Guttmacher Institute web site, http://www.agi-usa.org/state_facts/washington.html, 1999.

[36] San Juan County's abortion rate dropped from 18.6 per 1,000 in 1995 to 14 per 1,000 in 1996. *Washington State Pregnancy and Induced Abortion Statistics*, Center for Health Statistics, Washington Department of Health, 1997.

[37] On the island in which the clinic is located there is no other place to access emergency contraception; on other islands in the area, local pharmacies offer emergency contraception.

[38] There are a variety of mechanisms that provide emergency contraception, but most often the term refers to taking a combination of oral contraceptives within 72 hours of unprotected intercourse. Such emergency contraception reduces the risk of pregnancy by at least 75%. *A Pocket Guide to Managing Contraception*, Hatcher, Robert, et. al. 1999.

[39] Interview of Susan Joanis, Director, Macon-Bibb County Teen Center, by author; *Teen Parent Center Student Perinatal Profile, Students Delivering Spring Semester 1998* and *Teen Parent Center Student Perinatal Profile, Students Delivering Fall Semester 1998*, unpublished report of student data.

[40] "Mt. Baker Planned Parenthood Bellingham CSO Clinic, 1997-1998," , Mt. Baker Planned Parenthood, March 1999 (unpublished data charts). "Nearly one-third" figure provided by Linda McCarthy, Assistant Director, Mt. Baker Planned Parenthood, in interview by author.

[41] Cal-Learn sanctions can be imposed on participants for failure to meet school participation requirements; there are no sanctions related to contraceptive behavior.

[42] These sites include Forks, Washington; Stockton, California; and, San Luis Obispo, California.

[43] Among single adolescent mothers, 50% received AFDC benefits within a year after giving birth; and 77% received AFDC benefits with 5 years of giving birth. *Sources of Support for Adolescent Mothers*, Congressional Budget Office, September 1990. "About 42 percent (of single women receiving AFDC) were or had been teenage mothers. This proportion remained the same throughout the 17 year time period. . ." *AFDC Women Who Gave Birth as Teenagers*, GAO/HHS, 94-115, May 1994.

[44] A partnership between CLASP and the State Family Planning Administrators (SFPA) is assessing the nature and extent of interaction between family planning administrators and welfare agencies. Preliminary results from this project suggest that at least 34 states are using welfare funds for pregnancy prevention efforts.

[45] TANF financial data reported at http://www.acf.dhhs.gov/programs/ofs/data/q299/table-a-3.htm.

[46] *Family Planning at Community Service Offices*, Laurie Cawthon, Janet Campbell, Jonathan Lindsay, Research and Data Analysis, Washington Department of Social and Health Services, 1999; *WorkFirst Implementation Handbook*, WorkFirst Division, Economic Services Administration, Washington Department of Social and Health Services, 1997.

[47] Interviews of Linda McCarthy, Assistant Director, and Paula Armstrong, Clinic Manager, Mt. Baker Planned Parenthood, by author. Sharon McAllister, Program Manager, Family Planning and Reproductive Health, Washington Department of Health, says that the welfare department "often uses language that is very different from what we would use. They use forceful language that sounds coercive. They understand that, but they're coming from a different place," interview by author.

[48] At the drafting of this report, Georgia did not have disaggregated data identifying what percent of the clients have incomes at or below 150% of poverty.

[49] *Adolescent Health & Youth Development: A Prevention Support System for Youth*, Adolescent Health Youth Development Initiative, Family Health Branch, Division of Public Health, January 1999 (unpublished briefing book prepared for legislature).

[50] *Facts in Brief: Teen Sex and Pregnancy*, Alan Guttmacher Institute, 1998. *AFDC Women Who Gave Birth as Teenagers*, GAO HEHS 94-115, 1994.

[51] Counties do not have to use AFLP sites if: there is no AFLP, AFLP is not cost-effective, or there was an existing teen program operating under the welfare system. Interview of Chris Minnich, Manager, Teen Programs Unit, California Department of Social Services, by author.

[52] Most TANF programs are administered at the state level. California, along with 10 other states, either share this responsibility with the counties or devolve administration to the counties. *1999/2000 Public Human Services Directory*. American Public Human Services Association.

[53] *Family Planning at Community Service Offices*, Laurie Cawthon, Janet Campbell, Jonathon Lindsay, Research and Data Analysis, Washington Department of Social and Health Services, 1999.

[54] The official name of the Medicaid program in California is Medi-Cal. For the sake of simplicity, throughout this case study it is referred to as "Medicaid."

[55] *California Department of Social Services Eligibility and Assistance Standards Manual*, 40-107.62, California Department of Social Services.

[56] California has a county-based welfare system. There is an overarching state agency, referred to in this case study as "the welfare department," but many program implementation decisions are made at the county level.

[57] The welfare department entered into an interagency agreement with California State University Chico's Department of Journalism to help create and distribute materials for this project.

[58] Information provided by Jan Treat, Chief, Clinical Services Section, Office of Family Planning, California Department of Health Services. An evaluation of First Stop was published in 1998: *First Stop Program Evaluation Report*, University of California San Francisco Family Planning Institute, June 1998. There will be no subsequent final evaluation.

[59] The Modesto site, according to Samantha Phillips, who runs the program there. Interview of Samantha Phillips, Director of Family Planning, Stanislaus County Department of Health, by author.

[60] "Preliminary data suggest that client enrollment will increase by 60 percent over California's prior family planning program." *PACTFacts: Program Highlights*, California Department of Health Services, Office of Family Planning web site, http://www.dhs.ca.gov/pcfh/ofp/FamPACT/proghi.htm.

[61] All information on county usage of products provided by Debra Johnson, Project Manager, CalWORKS Family Planning Information Project, California State University, Chico.

[62] The program is for parenting teens who are the children's primary caregivers.

[63] Under federal requirements, a minor teen parent who is not a head of household (or married to a head of household) and who is in school full-time is not subject to federal time limits until she turns 19. For those who do not comply with Cal-Learn rules and are not in school, the state uses state funds to provide services; the use of state funds prevents the federal TANF time-limit clock from "ticking". California allows 19 year olds the option of participating in Cal-Learn as long as they are in school; however, the TANF time-limit clock "ticks" on them.

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[54] This figure is for those teens active in the program; at this date, 18,000 were enrolled. There is a delay between the date of enrollment and the date of program participation; also, some teens are enrolled by mistake and then removed from the program rolls without ever participating. Both figures provided by the California Department of Social Services.

[55] Other differences between the two programs are that Cal-Learn teens receive bonuses and sanctions relating to school performance, and they can also receive support services such as child care and transportation. AFLP teens do not receive either.

[56] Approximately 10% of the participants needed services but were not referred or were referred but no services were available. Data provided by the California Department of Social Services, which has an extensive data collection process for teens in the Cal-Learn program.

[57] TeenSMART information sheet, Office of Family Planning, California Department of Health Services, September 13, 1999.

[58] "Quarterly Report," *First Step Program Evaluation*, University of California San Francisco Family Planning Institute, January 1998.

[59] These Planned Parenthood agencies are in Garden Grove, King City, Pasadena, Santa Ana, and Tracy. Information collected via a CLASP survey of Planned Parenthood affiliates in California and an interview of Linda Williams, Chief Executive Officer, Planned Parenthood of Mar Monte, by author.

[60] Rules regarding sanctioning are set by each county in California, so welfare recipients could conceivably be sanctioned for missing a family planning class. However, of the several sites examined for this report, none sanction for this. Even in "zero tolerance" counties such as San Joaquin, where missing one part of the job training class technically results in a sanction, the coordinator, Rob Vasquez, says that in reality he works with clients to try to get them through the program, and they can generally miss several days without receiving a sanction if they have valid reasons. In addition, if they say that they do not want to be exposed to any family planning information, they are excused from the class (in San Joaquin, only a 15 minute presentation on services provided by the clinic occurs during the required class; more detailed information is provided in a later class for those recipients who sign up for it).

[61] The Cal-Learn evaluation is being conducted by U. C. Data, at the University of California, Berkeley. A process report was published in 1998, and an impact report is due to be published in January 2000. These reports are available at: http://ucdata.berkeley.edu/new_web/calearnintro.html. The Family PACT and TeenSMART evaluations are being conducted by the University of California, San Francisco and are due to be released by the California Office of Family Planning, Department of Health Services, in early 2000.

[62] The name of this program was originally Teen PLUS, but was changed to the Adolescent Health & Youth Development initiative, in 1999, in response to the controversy surrounding the program. Interview of Michele Ozumba, former Director of AHYD and consultant in the Division of Public Health, by author.
See subsequent discussion in the History & Development section for more detail on the controversy.

[63] This figure includes $3 million of the state's Indigent Care Trust Funds (a portion of the state's Medicaid monies). All references to funding figures for the AHYD initiative come from the author's interview with Ozumba, the former director of AHYD and consultant in the Division of Public Health.

[64] This funding was for FY 1999, which ran from July 1, 1998 through June 30, 1999. Interview of Michele Ozumba, former Director of AHYD and consultant in the Division of Public Health, by author.

[65] Comments of Bob Mayzes in a March 11, 1998 letter to the editor of the *Rome News Tribune*. It is ironic that despite the concerns about undermining parental authority, most minors receiving AHYD supported services do so with parental knowledge and often involvement. In Rome, for example, the teen center director notes that generally only college students seek confidential services. Younger teens most often come in with a parent. In fact, Marilyn

Ringstaff, the director, explains: "Parents are grateful for the services available and often drag their teens into the clinic for assistance."

[6] The statute, which was first enacted in 1971, is found in section 31-9-2 of the *Official Code of Georgia Annotated*.

[7] In this paragraph, the references to funding are for fiscal year allocations. FY 1997 was the initial allocation and FY 2000 was the most recent appropriation.

[8] In this paragraph, the years referenced are fiscal years. Thus, for example, 8,000 teens were served in teen centers between July 1, 1997 and June 30, 1998. The data for FY 1999, which ended June 30, 1999, were not available when this report was prepared. Interview of Michele Ozumba, former Director of AHYD and consultant in the Division of Public Health, by author; *Adolescent Health & Youth Development: A Prevention Support System for Youth*, Adolescent Health Youth Development Initiative, Family Health Branch, Division of Public Health, January 1999 (unpublished briefing book prepared for legislature).

[9] *Adolescent Health & Youth Development: A Prevention Support System for Youth*, Adolescent Health Youth Development Initiative, Family Health Branch, Division of Public Health, January 1999 (unpublished briefing book prepared for legislature).

[10] At the initiative's inception, Public Health ranked the counties according to the number of teenage births and offered grants to 15 sites in the counties with the highest numbers. The legislature identified an additional 12 sites so that 27 sites, in 21 counties, were awarded $150,000 AHYD grants. For FY 1999, additional priority counties were identified and the total number of sites receiving grants increased to 39. Interview of Michele Ozumba, former Director of AHYD and consultant in the Division of Public Health, by author; *Adolescent Health & Youth Development: A Prevention Support System for Youth*, Adolescent Health Youth Development Initiative, Family Health Branch, Division of Public Health, January 1999 (unpublished briefing book prepared for legislature).

[11] The funds are actually distributed to the regional health district encompassing the priority county. The funds are then generally distributed to the local health department for use in the teen center. However, the regional health district may contract with other agencies or entities rather than administering the teen center through the health department. Interview of Michele Ozumba, former Director of AHYD and consultant in the Division of Public Health, by author.

[12] *Adolescent Health & Youth Development: A Prevention Support System for Youth*, Adolescent Health Youth Development Initiative, Family Health Branch, Division of Public Health, January 1999 (unpublished briefing book prepared for legislature).

[13] *Adolescent Health & Youth Development: A Prevention Support System for Youth*, Adolescent Health Youth Development Initiative, Family Health Branch, Division of Public Health, January 1999 (unpublished briefing book prepared for legislature).

[14] The county welfare office's contribution to the school is distinct from the AHYD funds, which are administered by the health department and used to help support the adjacent teen center.

[15] The center director indicates that this requirement applies to only a handful of teens. Few teens are receiving TANF assistance, not attending the school and not working. The center director does not believe any of the teens who are subject to the requirement have been sanctioned for failure to comply. Interview of Susan Joanis, by author.

[16] Free child care is also available to teen parents who are not enrolled in the school for pregnant and mothering teens (both those who have returned to their home school and those who never enrolled in the school). However, transportation problems and the requirement that parents using the daycare attend the "extended day" program mean that almost all of the parents using the daycare are current students. Interview of Susan Joanis, Director, by author.

[17] Family planning services are available only after school is over. The clinical services may be accessed by any teens, regardless of whether they attend the school and regardless of whether they are pregnant or parenting.

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However, the center director reports that only a few teens who do not attend the school utilize the clinical services. She suspects this is because of a lack of transportation to the facility. Interview of Susan Joanis by author.

[55] Georgia policy permits local welfare offices to mandate participation in family planning education programs through individual responsibility agreements (IRA). *Two Sides of the Same Coin or a Toss of the Coin?: Family Planning Services and Family Cap Implementation*, Jodie Levin-Epstein, February 1999. Available at http://www.clasp.org.

[56] Most of the initiative's components are funded 90% by Medicaid and 10% by the state. The media campaign, for the most part, is funded 50% by each; its bus posters are entirely state-funded.

[57] Medicaid covers 60 days post-pregnancy, for all medical services. The state-funded expansion added 10 months for family planning services only. This coverage is for women who terminate pregnancies as well as for those who give birth. States that have broadened eligibility for family planning service beyond the regular Medicaid criteria use different terms to describe their programs; some call them extensions while others call them expansions. Washington's program is the "Family Planning Extension." However, in this report, all programs that broaden eligibility for family planning services are referred to as family planning expansions.

[58] In 1993-94, 69% of births to women on cash aid were unintended, and 55% of births to women who received Medicaid coverage because they were pregnant and their incomes were at or below 185% of the federal poverty level were unintended, while only 28% of births to women whose incomes were over 185% of poverty were unintended. Marital status was the factor most closely linked to pregnancy intention: among unmarried women, more than half of all births were unintended. Another important variable was age: 57% of unintended pregnancies occurred to women in their twenties. *Unintended Pregnancy*, Laura Schrager, Research and Data Analysis, Washington Department of Social and Health Services, June 1997.

[59] *Contraception Needs and Services: 1995*, Alan Guttmacher Institute, 1997.

[60] In Washington, the agency that administers Medicaid funds is the Medical Assistance Administration (MAA). MAA also manages the state-funded family planning expansion. For the sake of simplicity, throughout this case study MAA is referred to as "the Medicaid agency."

[61] "Family Planning Community Brainstorm Meetings: October 1991-September 1992," Claudia Lewis, Family Planning Program Manager, Medical Assistance Administration, Department of Social and Health Services, undated.

[62] House Bill 2798, Part 1, Section 3, State of Washington, 53rd Legislature, 1994 Regular Session; *Revised Code of Washington*, 74.12.410.

[63] *Family Planning at Community Service Offices*, Laurie Cawthan, Janet Campbell, Jonathan Lindsay, Research and Data Analysis, Washington Department of Social and Health Services, 1999.

[64] The family planning worker provides those services that do not require nursing certification.

[65] *Family Planning at Community Service Offices*, Laurie Cawthan, Janet Campbell, Jonathan Lindsay, Research and Data Analysis, Washington Department of Social and Health Services, 1999.

[66] In 1996, 44% of births in the county were paid for by Medicaid, and an estimated 40% of all births were from unintended pregnancies. *County Profiles: Birth and Unintended Pregnancy Statistics*, Washington Department of Social and Health Services, August 1998.

[67] If Ketchley knows clients are planning to terminate, she refers them to the family planning clinic for a pelvic exam, at which point birth control is discussed. These clients receive full Medicaid coverage up to the termination and for two months following the termination. They then receive 10 months of state-funded family planning coverage.

[101] "Mt. Baker Planned Parenthood Bellingham CSO Clinic, 1997-1998," Mt. Baker Planned Parenthood, March 1999 (unpublished data charts).

[102] Federal law allows but does not mandate states to cover over-the-counter contraception through Medicaid. Washington has elected to do so.

[103] In 1996, 54% of births in the county were paid for by Medicaid, and an estimated 42% of all births were from unintended pregnancies. *County Profiles: Birth and Unintended Pregnancy Statistics*, Medical Assistance Administration, Washington Department of Social and Health Services, August 1998.

[104] In 1996, 60% of births in the county were paid for by Medicaid, and an estimated 45% of all births were from unintended pregnancies. *County Profiles: Birth and Unintended Pregnancy Statistics*, Medical Assistance Administration, Washington Department of Social and Health Services, August 1998.

[105] *Family Planning in Washington State Community Services Offices: Challenges and Strategies*, Janet Campbell et al, Research and Data Analysis, Washington Department of Social and Health Services, August 1999.

Unless otherwise noted, the details about the initiatives in each of the three states are drawn from our interviews. More detailed citations are available from CLASP upon request.

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